

Blue Cross and Blue Shield of Minnesota Provider Policy & Procedure Manual

2024



**BlueCross BlueShield
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association

Summary of Changes (2024)

Chapter 1 – At Your Service

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
01/02/24	How to Contact Us	X		X	
	Provider Communications	X			

Chapter 2 – Provider Agreements

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
04/26/24	Clarifying Definitions for Quality Incentive and Gain/Risk Share Payment	X			

Chapter 3 – Quality Improvement

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
04/03/24	Clinical Practice Guidelines	X			

Chapter 4 – Care Management

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
01/02/24	Medical Policy	X			
	Prior Authorization/Notification	X			
	Where to Send Requests	X			
	Referrals to Case, Maternity and Condition/Disease Management	X			
	Documentation in the Medical Records	X			

Chapter 5 – Health Care Options

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
01/02/24	Blue Cross Medical Assistance Coverage Options	X			
1/12/24	Blue Cross Medical Assistance Coverage Options	X			

Chapter 6 – Blue Plus

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 7 – BlueCard

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
01/24/24	Cosmetic update only				

Chapter 8 – Claims Filing

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
03/21/24	Professional/837P Billing	X			

Chapter 9 – Reimbursement/Reconciliation

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted

Chapter 10 – Appeals

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
03/21/24	Provider Appeals	X		X	

Chapter 11 – Coding Policies and Guidelines

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
02/08/24	Claims Audits	X			

Chapter 12 – Pharmacy Services

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
01/24/24	Medication Therapy Management	X			

Chapter 13 – Minnesota Health Care Programs

Date	Topic Changes	Type of Change(s)			
		Content	New Topic	Deletions	Topic Deleted
01/02/24	Minnesota Health Care Programs	X		X	

Chapter 1

At Your Service

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Introduction

Provider Policy and Procedure Manual

Blue Cross and Blue Shield of Minnesota developed the *Provider Policy and Procedure Manual* for participating health care providers and your business office staff. This manual provides information about our claims filing procedures, payments, provider agreements, managed care requirements, communications and other topics that affect patient accounts and patient relations. As policies and procedures change or clarification is needed, Blue Cross will keep you updated through *Provider Bulletins*, *Quick Points* and the *Provider Press*, found at bluecrossmn.com. Information in this manual is a general outline and is part of your provider contract. Provider and subscriber contracts determine benefits.

Blue Cross and Blue Shield Plans

Blue Shield plans for professional services began to form across the nation in the 1940s, after the successful Blue Cross movement of the 1930s was well underway. Today, there are many Blue Cross and Blue Shield Plans throughout the United States. Blue Cross and Blue Shield Plans may be separate companies or combined as one company. Each plan is an independent business organization and a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

The Blue Cross and Blue Shield Association, headquartered in Chicago, is an association of independent Blue Cross and Blue Shield Plans. It sets performance standards and bids for national contracts and programs. It also organizes advertising campaigns, conducts research and coordinates legislative efforts on behalf of the association's subscribers.

Blue Plus

Blue Plus, an affiliate of Blue Cross, is a state-certified health maintenance organization (HMO). In most Blue Plus products, subscribers select a participating primary care clinic that coordinates all of the patient's medical care and authorizes treatment by specialists when necessary.

Because Blue Plus is an affiliate of Blue Cross, Blue Plus is subject to most of the same policies and procedures. For general information about Blue Plus, you may refer to Chapter 6 of this manual. Blue Plus primary care clinics should refer to the *Blue Plus Provider Manual* for specific Blue Plus guidelines. Blue Plus is a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

CPT® Copyright

CPT codes copyright 2010 American Medical Association. All Rights Reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

How to Contact Us

Provider Services

A conversation with one of our service representatives often can solve a problem immediately or give you an answer to a claims question. The representatives answering the provider services numbers are available to assist you:

- Monday – Friday7 a.m. – 6 p.m.

Please have your provider number or NPI and, if applicable, the subscriber's identification number, account number and claim number ready when you call. The provider services telephone numbers listed are for the **provider's use only**. Please refer subscribers to the customer service telephone number on the back of their subscriber identification (ID) card.

The general provider services phone numbers are **(651) 662-5200** (Twin Cities area) and **1-800-262-0820** and **1-888-420-2227**

The general provider services fax number is **(651) 662-2745**.

Minnesota Health Care Programs provider services phone numbers are as follows:

For all questions, including eligibility and benefits, utilization management, or claims, contact Provider Services at 651-662-9962 or toll free at 1-866-518-8448.

For questions regarding your contract, credentialing, or demographic set up: **1-800-262-0820**

Federal Employee Program

Providers who are calling to check eligibility and benefits for Federal Employee Program subscribers can utilize the voice response unit specific to FEP.

Claim status is not available at this time. Providers will be prompted to speak to a service representative for all FEP claims questions. To access this service, call **(651) 662-5044** or **1-800-859-2128**. FEP subscribers are recognized by an "R" followed by eight numeric digits in their identification number.

Calls Not Handled by Provider Services

Calls for the accounts on the next page are not handled by provider services. Please use the phone numbers listed. In addition, calls from independent social workers who are working as patient advocates should call the customer service phone number on the back of the subscriber's ID card.

Calls Not Handled by Provider Services (continued)

Accounts and how to ID them	Phone Numbers
Federal Employee Program ID number starts with an R	(651) 662-5044 1-800-859-2128

BlueCard® Benefits and Eligibility

To verify benefits or eligibility for BlueCard subscribers, call **1-800-676-BLUE (2583)**. Refer to *Chapter 7* for additional information.

Provider Claim Adjustment/Status Check

The [Provider Inquiry Appeal Form.docx \(bluecrossmn.com\)](#) is designed for non-Minnesota providers to fax or mail their inquiries to Blue Cross.

The applicable fax number is listed on the form or mail it to the general Blue Cross address (see below).

All the fields are required to be completed, if applicable. Make sure to clearly state the contact name, phone number and contact's fax number.

The inquiries can be an adjustment request or claim status request for regular or BlueCard business.

The form will not be returned to you unless Blue Cross needs clarification on your request. All adjustments that are completed will be found on a future remittance advice.

General Address

The general address is:

Blue Cross and Blue Shield of Minnesota
 P.O. Box 64560
 St. Paul, MN 55164-0560

Claims Address

All claims must be submitted electronically. All Minnesota and out-of-state participating providers are required to electronically submit all claims according to Minnesota Statute 62J.536 and the participating provider contracts. Paper claims will be rejected to be resubmitted electronically. Blue Cross will not consider such paper claims to have been received until resubmitted electronically. Nonparticipating out-of-state providers may submit a scannable claim form to:

Blue Cross and Blue Shield of Minnesota
Document Processing Center
P.O. Box 982805
El Paso, TX 79998-2805

Send adjustments and appeals to:

Blue Cross and Blue Shield of Minnesota
Document Processing Center
P.O. Box 982800
El Paso, TX 79998-2800

Availity Provider Portal

In lieu of faxing and calling, Providers are directed to create and inquire on the status of utilization management authorization requests electronically on our provider portal at [Availity.com](https://www.availity.com).

Out-of-state providers that participate with any Blue Cross and Blue Shield plan can access Availity through the out-of-area member router provided by each state's plan.

The Availity Authorization portal should be used for all required preservice inpatient and outpatient prior authorization requests. The Availity Authorization portal should also be used for admission notifications, unless your facility is submitting a 278 or ADT HL7 transaction (see Provider Bulletin P15-18 for more details).

Requests for medical necessity review of services that have already been provided cannot be submitted online and will not be accepted by phone or fax.

Questions?

If you have questions, please contact provider services at **(651) 662-5200 or 1-800-262-0820**.

Care Management Numbers and Addresses

The phone numbers, fax numbers and addresses for care management programs and services are listed below.

Providers have the ability to create, submit with attachments and inquire on status of utilization management authorizations electronically via the Availity portal at [Availity.com](https://www.availity.com). The Availity Authorization Portal should be used for all pre-service in-patient, pre-service out-patient authorization requests and admission notifications.

Providers have the ability to request a concurrent review on an existing in-patient authorization via Availity Providers. Additionally, providers are able to inquire on the status of utilization management requests and will also see a dashboard of authorization requests, including status, for authorizations entered via the Availity Authorization Portal.

The most current preauthorization (PA) list and current medical policies are located on the Blue Cross website: providers.bluecrossmn.com under “Tools and Resources”. Additional review guidelines are also found in chapter four of this manual, *Care Management*. Providers can also contact Provider Services at **1-800-262-0820** for assistance.

Area	Phone/Fax Numbers and Addresses
------	---------------------------------

Care Management Numbers and Addresses

Area	Phone/Fax Numbers and Addresses
<p>The following pre-service requests should be submitted on Provider self-service:</p> <ul style="list-style-type: none"> • Inpatient Precertifications • Admission Notifications • Outpatient Pre-Service Requests (Medical and Behavioral Health) • Home Health Services • Home Infusion Services • Hospice Care • Skilled Nursing Facility Requests • Transplant Requests <p>The following pre-service requests can be mailed or faxed:</p> <ul style="list-style-type: none"> • Predeterminations 	<p>Provider self-service: www.availity.com</p>
<p>Admission Notification and Inpatient Admission Pre-Certification Review</p> <p>For medical and behavioral health related inpatient admissions</p>	<p>General inquiries:</p> <p>Phone: (651) 662-5270 1-800-528-0934</p> <p>Fax: (651) 662-7006</p> <p>Fax: (651) 662-0622 or 1-855-315-4038</p>

**Care Management
Numbers and
Addresses (continued)**

Area	Phone/Fax Numbers and Addresses
Minnesota Health Care Programs Inpatient Admission Pre-Certification Review	Authorizations can be submitted via phone or fax by providers that do not participate with MN Encounter Alert Service (MN EAS) Phone: 866-518-8448 Fax: Families & Children, MSC+, MNCare and MSHO: 651-662-6283
Skilled Nursing Facility Admission Review	General inquiries: Commercial Fax: (651) 662-1004 Medicare Programs <ul style="list-style-type: none"> • Phone: (651) 662-5540 (Initial review) • Fax: (651) 662-4022 (Concurrent review) Minnesota Health Care Programs <ul style="list-style-type: none"> • Phone: 866-518-8448 PMAP communication form: Fax: <ul style="list-style-type: none"> • Blue Advantage MSC+ and SecureBlue MSHO: 651-662-6283

**Care Management
Numbers and
Addresses (continued)**

Area	Phone/Fax Numbers and Addresses
Behavioral Health Review (Outpatient)	General inquiries: Fax: (651) 662-0854 Mail: Integrated Health Management Behavioral Health, R472 P.O. Box 64265 St. Paul, MN 55164-0265
Home Care Review The following pre-service requests should be submitted on Provider self-service: <ul style="list-style-type: none"> • Home Health Services • Home Infusion Services • Hospice Care 	General inquiries: Fax: (651) 662-1004 Mail: Integrated Health Management Allied Team, R472 P.O. Box 64265 St. Paul, MN 55164-0265
Urgent Outpatient Medical Procedure Review Only submit requests that meet the federal definition of “Urgent” to this fax line: where applying the standard review time may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.	General inquiries: Fax: (651) 662-1624
Non-urgent Outpatient Medical Procedure Review	General inquiries: Fax: (651) 662-2810 Mail: Integrated Health Management Utilization Management, R472 P.O. Box 64265 St. Paul, MN 55164-0265

Other Numbers and Addresses

These phone numbers, fax numbers and addresses may be helpful to you.

Company	Phone Number	Address
BlueLink TPA SM	Refer to Subscriber's ID card	BlueLink TPA SM P.O. Box 64668 St. Paul, MN 55164
Delta Dental [®] of Minnesota SM	(651) 406-5900 or 1-800-328-1188 Fax: (651) 406-5934	Delta Dental of Minnesota SM 3560 Delta Dental Drive Eagan, MN 55122
United Concordia Dental	(800) 332-0366	4401 Deer Path Road Harrisburg, PA 17110 Or PO Box 69420 Harrisburg, PA 17106-9420
MII Life Inc. SM	(651) 662-5065 1-800-859-2144	MII Life Inc SM 3535 Blue Cross Road P.O. Box 64193 St. Paul, MN 55164-9828
Prime Therapeutics LLC	(612) 777 -4000 or 1-800-858-0723 Pharmacy help desk: 1-800-821-4795 (for pharmacist or doctor use only)	Prime Therapeutics [®] 2900 Ames Crossing Road Eagan, MN 55121
Customer Service	Refer the subscriber to their customer service number printed on the back of their subscriber ID card. They may also call (651) 662-8000.	
Fraud Hot Line	(651) 662-8363 or 1-800-382-2000 ext. 28363	
Medicare & More Customer Service	(651) 662-5020 or 1-800-531-6686	

**Address Changes and
Other Demographic
Information**

Promptly notify Blue Cross when any of your demographic information changes, including but not limited to your address, phone number, hospital affiliation or office hours. Use the Provider Demographic Change Form, available at bluecrossmn.com/providers. Enter “provider demographic change form” in the search window. Blue Cross uses your demographic information in provider directories, to help subscribers find you easily, mail important information to you, etc. Call **(651) 662-5200** or **1-800-262-0820** for telephonic assistance. Email completed forms to provider.data@bluecrossmn.com, fax to **(651) 662-6684** or mail the forms to:

Blue Cross and Blue Shield of Minnesota
Provider Data Operations
P.O. Box 982809
El Paso, TX 79998-2809

- Blue Cross shall in its sole discretion, determine if a participating agreement will be extended to an acquired entity and/or additional locations of Provider.

EviCore Contact Information

Program	Fax Number
MN eviCore – Genetic Testing (Molecular/Genetic Lab) Program	844-545-9213
MN eviCore – Medical Oncology Program	866-699-8160
MN eviCore – Musculoskeletal (MSK) Program	800-540-2406
MN eviCore – Radiation Oncology (Radiation Therapy) Program	800-540-2406
MN eviCore – Advanced Imaging (Radiology/Cardiology) Program	800-540-2406
MN eviCore – Sleep Management Program	866-999-3510
MN eviCore – Post Acute Care (PAC) – Durable Medical Equipment	866-663-7740
MN eviCore – Post Acute Care (PAC) – Post Acute Care <ul style="list-style-type: none"> • Skilled Nursing Facility (SNF) • Long Term Acute Care (LTAC) • Inpatient Rehabilitation Facilities (IRF) • eviCore Customer Service Phone: 844-224-0494 	888-738-3916
MN eviCore – Post Acute Care (PAC) – Home Health <ul style="list-style-type: none"> • Aide • Diagnostic Lab • Occupational Therapy • Physical Medicine • Skilled Nursing Care • Social Worker • Speech Therapy 	866-506-3087

BLUELINE

Introduction

BLUELINE is a voice response system for our health care providers. It furnishes immediate information regarding covered Blue Cross subscribers.

BLUELINE offers callers the following information:

- Pre authorization
- Subscriber specific claim*
- Subscriber specific eligibility*
- Subscriber specific benefit*
- Subscriber specific primary care clinic

*A fax back of this information is available by following the menu options within BLUELINE.

BLUELINE Availability

BLUELINE is available 24 hours a day, seven days a week; except during scheduled maintenance.

Calling BLUELINE

You can access BLUELINE by calling **(651) 662-5200** or **1-800-262-0820**.

If the information you are requesting is not available within BLUELINE, you will be automatically routed to a service representative during normal service hours:

Monday-Friday.....7 a.m. – 6 p.m.

System Assistance

If you require assistance in accessing BLUELINE or have not received your fax, call technical support at **(651) 662-5555** or toll free at **1-800-711-9871** and select option three. Blue Cross will need the following information:

- Provider number and name
- Date and time of occurrence
- Caller's name and telephone number
- Description of the problem
- Fax number, if applicable.

Provider Identification Provider identification is required for obtaining claim information or requesting a Fax back of claim information for a specific subscriber.

BLUELINE will prompt you when necessary for your provider ID. Your choices will be “Blue Cross Blue Shield of Minnesota Provider ID,” “NPI” or “TAX ID.”

You may request any of these options just by speaking the words – such as saying, “NPI.” BLUELINE will then prompt you for the actual numbers for just that ID. Just speak naturally, one character or number at a time.

Subscriber Identification When BLUELINE prompts you for the subscriber ID, just speak the numeric portion or enter it using your touch-tone keypad. For example, if the subscriber ID is XZA XZ1234567, just speak or enter 1234567, one digit at a time.

Date When BLUELINE prompts you for the date of birth or date of service, just say the date naturally, for example March 17, 1964 or 3-17-1964. You may also enter the date using your touch-tone keypad. If using the keypad, enter all eight digits – i.e. 03171964.

Provider Web Self-Service

Availity

Blue Cross contracted with Availity to give providers more HIPAA 5010 self-serve resources. Providers can access subscriber eligibility, benefits, network, claim status and remittances, coordination of benefit information, referrals, pre-service requests, admission notifications, PCCs, and recoupments. The portal is available at www.availity.com Providers must complete the registration process for specific electronic transactions.

The system is available 24 hours a day, 7 days a week, except for scheduled maintenance times.

To register, contact www.availity.com or call **1-800-AVAILITY**.

Availity is an independent company providing claims administration services.

ID Cards

Introduction

Your patient's subscriber ID card contains information that is essential for claims processing. Blue Cross recommends that you look at the patient's ID card at every visit and have a current copy of the front and back of the card on file. There is a sample of some of the ID cards issued from Blue Cross on our website. Some of the following information may be found on the ID card:

- Name of the plan
- Subscriber's ID number including three-character (alpha/numeric) prefix
- Subscriber's name and group number
- Primary care clinic (PCC) name – for managed care plans only
- Blue Shield plan code
- Blue Cross plan code
- Prescription coverage
- Copay for prescription drugs
- Copay for office visits
- Dependent coverage indicator
- Claims submission information

ID Cards

Blue Cross and its affiliates do not use Social Security numbers for subscriber identification numbers

Helpful Tips

Blue Cross plans have the option of creating identifiers with any combination of up to 14 letters or digits following the three-digit alpha/numeric prefix.

- Verify the identity of Blue Cross and Blue Plus cardholders by asking for additional picture identification. If you suspect fraudulent use of a subscriber ID card, please call our fraud hot line at **(651) 662-8363**. You may remain anonymous.
- Ask subscribers for their current subscriber ID card and regularly obtain new photocopies (front and back). Having the current card will enable you to submit claims with the appropriate subscriber information and avoid unnecessary claims payment delays.
- Check eligibility and benefits by using provider web self-service, BLUELINE, or call **1-800-676-BLUE** (2583) and provide the alpha/numeric prefix for BlueCard eligibility.
- If the subscriber presents a debit card be sure to verify the copayment, deductible, or other amounts owed are accurate before processing payments. Subscribers cannot be required to make such payments in advance of the claims being processed.
- Do not use the card to process full payment up front. If you have questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Electronic Commerce

Overview

An important part of Blue Cross' cost containment strategy is automating the electronic exchange of information.

Electronic Transactions

Blue Cross accepts the submission and/or generates the following HIPAA compliant transactions:

- Health Care Claim (837 P, I and D)
- Health Care Claim Payment/Advice (835)
- Health Care Eligibility Benefit Inquiry and Response (270/271)
- Health Care Claim Status Request and Response (276/277)
- Health Care Services Review- Request for Review and Response (278)

Blue Cross uses Availity for exchanging HIPAA mandated EDI transactions. You can get information on how to register and conduct electronic transactions through Availity by going to www.availity.com.

Electronic Data Interchange (EDI) Guidelines

- Minnesota Statute 62J.536 requires all Minnesota providers and Minnesota group purchasers to exchange three transactions electronically: Health Care Claims, Health Care Claim Payment/Advice and Health Care Eligibility Benefit Inquiry and Response. In addition, participating out-of-state providers are required by contract to adhere to these electronic requirements.
- All nonparticipating, out-of-state providers who do not have electronic claim submission capabilities must submit their claims on an optical character recognition scannable claim form.
- All nonparticipating, out-of-state providers who are receiving direct payment must access their remittance advice via use of the electronic transaction or provider web self-service.
- Blue Cross reserves the right to modify these guidelines with advance written notice.
- Providers are encouraged to obtain or develop EDI transaction software from the many sources available.

Remote Access Services

Providers may be permitted to use Blue Cross' remote access services, allowing them to obtain specific subscriber information and other information necessary for submitting claims and viewing claim status or payment information. Access may not be transferred to another entity by the provider and Blue Cross retains all rights to the computer software system. Providers may only use the system to:

- Verify health plan coverage benefits of their patients
- Verify claims status
- Verify cases (such as referrals and admission notifications)
- Create and update referrals (available only for primary care clinics)
- Create and update admission notifications (available only to primary care clinics and inpatient facilities)
- For external security delegated administration
- View remittance advice information
- Other purposes to be communicated by Blue Cross

Providers have certain responsibilities when using Blue Cross' remote access services. They include:

- Access is for the provider only, and third parties may not have access to the system without advance written approval of Blue Cross.
- Blue Cross is the sole and exclusive owner of the system and its components, and the provider does not have any rights to it, either intellectual property rights or other rights of any kind.
- The provider may not reverse assemble, decompile, duplicate or modify the system or any parts of it.
- At any time, Blue Cross may modify or enhance the system, or replace the system with an entirely new system.
- Provide all necessary components for using Blue Cross' system, such as compatible software, hardware, access to the Internet and any other necessary technology to access the system.
- Blue Cross may discontinue the provider's access to the system or terminate use of the system upon thirty (30) days advance written notice to the provider.

**Remote Access
Services
(continued)**

Providers may access Blue Cross' system via the Internet (or other technology as approved by Blue Cross) at any time, except when the system is undergoing maintenance or repairs, or due to interruptions beyond the control of Blue Cross. Providers are solely responsible for the necessary software, hardware, access to the Internet, and other technology or services necessary for providers to use the system.

Only authorized users may access the system and use its services.

- Authorized users are employees of the provider and others included in the provider's workforce (in accordance with 45 C.F.R. 160.103).
- The provider must designate authorized users and obtain access through Blue Cross for them to use the system, either through a user request form or directly entering into the system the information required on the user request form.
- Blue Cross will assign a user name upon acceptance of the user request form.
- Each individual user name and password and each Blue Cross assigned user identification number/code and password is used only by the respective authorized user and may not be shared with anyone.
- The provider must provide immediate written notification to Blue Cross whenever an authorized user terminates employment with the provider.
- The provider must also notify Blue Cross of any other changes, deletions and/or modifications to information originally submitted on the user request form.

**Remote Access
Services
(continued)**

Disclaimer: Provider's use of the services and the system and any information obtained there is subject at all times to instructions, notices and/or disclaimers appearing online on the system from time to time.

- The services and the system are provided "AS IS" and Blue Cross makes no representation or warranty that the system will meet provider's requirements or that the system will operate uninterrupted or error free, or that the information obtained is or will be accurate.
- Blue Cross makes no warranties of merchantability, fitness for a particular purpose, non-infringement or otherwise, all of which are expressly disclaimed.

Payment: Blue Cross reserves the right to require providers to pay remote access service fees. In such an event, Blue Cross will provide at least 90 days' advance written notice to providers. Such fees will be due and payable within 30 days of any invoice and late payments will be subject to interest at a rate of the lesser of (a) one and one-half percent per month or (b) the highest rate allowed by law.

Limitation of Liability: Blue Cross' entire liability to provider for any and all damages incurred by provider for any and all claims arising out of, or otherwise relating to remote access services described above shall in the aggregate not exceed 100 percent of the total remote access services fees received by Blue Cross. Blue Cross will not be liable for any damages caused by provider's failure to perform its responsibilities and/or for any indirect, special or punitive damages, even if Blue Cross has been advised of or is otherwise aware of the possibility of such damages.

Provider Communications

Provider Communications

Blue Cross publishes many communications for providers including those listed below. They are available on our website at bluecrossmn.com/providers.

Title	Description
<i>Provider Bulletins</i>	Blue Cross communicates immediate policy and procedure changes through Provider Bulletins. The Provider Bulletins are contractually binding. Portions of this manual will also be updated periodically to reflect policy and procedure changes.
<i>Provider Quick Points</i>	This is a communication tool that Blue Cross is using to get helpful information to you.
<i>Medical Policy Update</i>	Changes to Medical Policy impacting payment are communicated through Provider Bulletins. The updates contain a summary of medical technologies that have been reviewed, revised, or are new to Blue Cross' investigative list.
<i>Blue Plus Referral Network for Primary Care Clinics</i>	This is a listing of specialty providers for referral purposes.
<i>Blue Plus Manual</i>	The Blue Plus Manual provides additional information about the Blue Plus business, referrals, contacts, quality improvement and Minnesota Health Care Programs.

Subscriber Rights and Responsibilities

Health Plan Subscribers have the Following Rights

Blue Cross and Blue Shield of Minnesota Enrollee Rights and Responsibilities

YOU HAVE THE RIGHT AS A HEALTH PLAN
SUBSCRIBER:

- To be treated with respect, dignity and privacy.
- To have available and accessible medically necessary covered services, including emergency services, 24 hours a day, and seven (7) days a week.
- To be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless, if the health plan pays for treatment.
- To participate with your health care providers in decisions about your treatment.
- To give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in event of incapacity).
- To refuse treatment.
- To have privacy of medical and financial records maintained by Blue Cross and its health care providers in accordance with existing law.
- To receive information about Blue Cross, its services, its providers and your rights and responsibilities.
- To make recommendations regarding these rights and responsibilities policies.
- To have a resource at Blue Cross or at the clinic that you can contact with any concerns about services.
- To file a complaint with Blue Cross and the Minnesota Commissioner of Commerce and receive a prompt and fair review.
- To initiate a legal proceeding when experiencing a problem with Blue Cross or its providers.

**Health Plan
Subscribers have the
Following
Responsibilities**

**YOU HAVE THE RESPONSIBILITY AS A HEALTH PLAN
SUBSCRIBER:**

- To know your health plan benefits and requirements.
- To provide, to the extent possible, information that Blue Cross and its providers need in order to care for you.
- To understand your health problems and work with your doctor to set mutually agreed-upon treatment goals.
- To follow the treatment plan prescribed by your provider or discuss with your provider why you are unable to follow the treatment plan.
- To provide proof of coverage when you receive services and to update the clinic with any personal changes.
- To pay copays at the time of service and to promptly pay deductibles, coinsurance and if applicable, charges for services that are not covered.
- To keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

Chapter 2

Provider Service Agreements

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Participation and Responsibilities

Advantages of Participation

Advantages of being a Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) participating provider include:

- Direct payment from Blue Cross reduces administrative expense and improves cash flow
- Blue Cross Subscribers have financial incentives to use participating providers.
- Participating providers' names are included in directories that Blue Cross publishes for its Subscribers.
- Blue Cross Provider Service Agreements do not contain exclusivity clauses that prohibit providers from participating with other Health plans.
- Participating providers receive a *Statement of Provider Claims Paid* explaining how claims are processed.
- Opportunity to attend provider seminars offered free of charge by Blue Cross
- Dedicated service staff available to assist participating providers.
- Electronic options such as provider web self-service to obtain information

Responsibilities of Participating Providers

Responsibilities of being a participating provider include:

- Participating providers are required to maintain internet capabilities to access online Blue Cross Provider Resources. This may include but is not limited to Provider Communications (Provider Bulletins and Provider Press), Availability, or other tools and resources.
- Participating providers are required to electronically submit all claims. Paper claims will be rejected and will need to be submitted electronically. Blue Cross will not consider such paper claims to have been received until resubmitted electronically.
- Participating providers are encouraged to have and continuously maintain cyber liability insurance to cover first-party and third-party liability for data privacy and cybersecurity claims related to data breaches, unauthorized access/use of data, damage/loss/theft of data, invasion of privacy, release of private information, cyber extortion, and business interruption, including any related costs for legal advice, forensic and internal investigations, crisis management, regulatory fines and penalties, credit monitoring, notifications, data recovery and business income loss and expenses.

Responsibilities of Participating Providers (continued)

- Participating in the Blue Cross credentialing process.
- Participating in Blue Cross managed care programs.
- Submitting admission notifications or prior authorizations or Pre-certifications when required, must be submitted through Availity.
 - Exceptions to this are:
 - Admissions for BlueLink TPA Subscribers
 - If a clinic/facility does not have web access
 - For these exceptions only, PANs may be faxed to **(651) 662-6860**.
 - All PANs for Portico Benefit Services (prefixes ELP and PBR) are conducted by Quantum. Provider should contact Quantum directly using the number on the back of the ID card.
- Referring Subscribers to other participating Blue Cross providers and facilities.
- Accepting payment provisions outlined in the Provider Service Agreement. If Blue Cross determines that Health Services are experimental, investigative, or not Medically Necessary, providers may not bill the Subscriber unless the provider gives the Subscriber written notification of non-coverage immediately before the Health Services are performed and the Subscriber agrees in writing to be responsible for the Health Services.
- Notifying Blue Cross of new programs prior to implementation (i.e., technology, new procedures being performed, services performed in a particular setting).
- Maintaining confidentiality of Blue Cross' contractual and financial arrangements.
- Ensuring Health Services rendered by all providers are within the scope of the provider's registration, license, and training and consistent with community standards for quality and utilization.
- Not billing Blue Cross for any professional services provided by Health Care Professionals to themselves, their immediate family members or those living in the same household. Immediate family members include the Health Care Professional's spouse, children, parents or siblings.

Responsibilities of Participating Providers (continued)

- Promptly furnishing at the provider's own expense any additional information that Blue Cross or the Plan Sponsor shall reasonably request as necessary to respond to claims, utilization review, audits, coordination of benefits, quality improvement and care management reviews, pre-certification reviews, admission notification, prior authorization, medical necessity reviews, credentialing, and medical abstract reports. The provider shall be responsible for obtaining any authorization required to release such information to Blue Cross or the Plan Sponsor.
- Collecting appropriate copayment amounts and not waiving these amounts.
- Billing the Subscribers for services listed as exclusions in the Subscriber Contract.
- Participating providers may not collect any difference between the amount billed and Blue Cross' allowance for Health Services from Subscribers or the Subscriber's employer.
- Charging the general public, the same amounts as Blue Cross Subscribers (individual hardship cases are an exception).
- Billing only for Health Services personally performed by Provider's medical staff or other Health Care Professionals employed by Provider or facility that meet the eligibility criteria defined by Blue Cross.
- Providers who provide health, prescription drug or administrative services to Medicare subscribers must meet the Centers for Medicare & Medicaid Services (CMS) general compliance and fraud, waste, and abuse (FWA) training. All Provider types are required to submit an attestation form annually. Training materials and the Attestation of Training completion form are available at providers.bluecrossmn.com, select Education center then Medicare education.

**Requirements of
Minnesota Law**

Minnesota law requires participating providers to look to Blue Cross for payment of Health Services covered by the Subscriber Contract. Following are requirements:

- Providers may not bill Subscribers for Health Services covered by their Blue Cross Health Plan, but bill only in accordance with Minnesota law for the applicable coinsurance, copayment or deductible. Providers may not withhold treatment in the event that a Subscriber is unable to make payment in advance or prior to Blue Cross completing processing of the claim or adjustment.
- Providers may not refer a Subscriber's account to collection for nonpayment of services covered by the Blue Cross Health Plan. Copayments, coinsurance, and deductibles can be coordinated through provider's normal billing, and if applicable, its collections process.
- Interest on Health Services covered by Blue Cross may not be applied to a Subscriber's account.

Price Disclosure

Effective July 1, 2019, in accordance with Minnesota Statute 62.J.81, Provider must provide the patient with information regarding other types of fees or charges that the patient may be required to pay in conjunction with a visit to the Provider, including but not limited to any applicable facility fees, within ten business days from the day of a completed request.

In addition, Provider shall maintain a list of the services over \$25 that correspond with the Provider's 25 most frequently billed current procedural terminology (CPT) codes. This list shall be updated annually and must be posted in the Provider's reception area of the clinic or office and made available on the Provider's Web site if the Provider maintains a Web site. No contract between a Provider and Blue Cross prohibits any of these price disclosures. Price disclosure is not a guarantee of final costs for Health Services received nor a final determination of eligibility of coverage.

**Requirements of
Minnesota Law
(continued)**

- Effective August 1, 2010, Minnesota Statute [62Q.751] allows:
 - Providers may collect deductibles and coinsurance from Subscribers at or prior to the time of service.
 - Providers may not withhold a service to a Subscriber based on a Subscriber's failure to pay a deductible or coinsurance at or prior to the time of service.
 - Overpayments by Subscribers to providers must be returned to the Subscriber by the provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by the provider.

**Requirements of
Consolidated
Appropriations Act of
2021("CCA")**

The Consolidated Appropriations Act of 2021 ("CAA") Section 201 prohibits Blue Cross from entering into contracts with providers that prevents disclosure of cost or quality information to referring providers, plan sponsor, members and individuals eligible to become members.

In addition, no contract terms can deny Blue Cross from electronically accessing de-identified member claims and encounter measures from provider upon request, consistent with HIPAA privacy regulations.

Emergency Services:

Blue Cross Subscribers will not be balanced billed for out of network emergency services and out of network providers at an in-network facility for emergency services, unless a specific exception is created in writing, as defined by the Department of Health and Human Services. Emergency services cost-sharing is also applicable to air ambulance emergency services.

Blue Cross' Responsibilities

Blue Cross' responsibilities include the following:

- Make payment directly to participating providers for covered Health Services, respond to inquiries and resolve claims in a timely manner.
- Maintaining confidentiality of a provider's charge data in accordance with the terms of the Provider Service Agreement
- Establishing a peer-review process to make decisions about Medical Necessity.
- Keeping Subscribers informed of participating providers through publication of directories.
- Keeping providers informed of changes which are contractually binding through Provider Bulletins or other communications (e.g., Provider Policy & Procedure Manual)
- Effective April 26, 2017, Minnesota Statute [62Q.556] requires:
 - Blue Cross to provide coverage at the in-network level of benefits for billing of unauthorized provider services. Unauthorized provider services include services received from a nonparticipating provider at a participating hospital or ASC and services received from a participating provider that sends a specimen taken from a Blue Cross Subscriber to a nonparticipating facility without Subscriber's written consent. Emergency services are not considered unauthorized provider service.
 - Blue Cross will provide coverage and cost sharing calculations for emergency services in accordance with the 2021 Consolidated Appropriations Act (CAA). Such calculations shall not take into account whether a prior authorization is required, and cost sharing shall be calculated at the in-network level.
 - With respect to groups for whom Blue Cross is the claims administrator, Blue Cross to attempt to negotiate reimbursement for unauthorized provider services with a nonparticipating provider which includes an option to exercise binding arbitration in the event agreement cannot be reached.

**Written Notification
and Provider Liability**

If it is necessary to recommend that a Subscriber see a nonparticipating provider, the participating provider must give the Subscriber advance, written notification that the recommendation is to a nonparticipating provider. Once notice is given, the Subscriber is responsible for any increased liability if he or she decides to schedule the service.

If a Subscriber is not properly informed, the provider making the recommendation to a nonparticipating provider will be liable for increased costs that a Subscriber incurs. Please refer to *Waivers* in Chapter 4.

**Provider Service
Agreements
Notification**

Provider Service Agreements (Agreements) are modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreements. Blue Cross communicates substantive changes to the Agreements annually via Provider Bulletin. A comprehensive copy of the Agreements can be requested from the following email box: Request.Contract.Renewal@bluecrossmn.com. A complete copy of the Agreement will be sent.

National Provider Numbers

Overview

Blue Cross works with many different types of providers through its Provider Service Agreements to establish networks of participating providers.

National Provider Number (NPI)

The Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA-AS) is the result of legislation passed by the U.S. Congress. The legislation mandates standards for business-to-business electronic data interchange and code sets, establishes uniform health care identifiers and seeks protection for the privacy and security of patient data.

The purpose of implementing the NPI is to improve the efficiency and effectiveness of the health care system by reducing the number of identifiers associated with any specific provider or provider facility. Implementation will simplify provider identification and billing processes across multiple third-party payers (including government programs) and prevent fraud and abuse.

The NPI is a unique all numeric 10-digit number that is assigned by the Centers for Medicare & Medicaid Services (CMS). NPI eligible providers are to submit transactions with the NPI at the facility level as well as the practitioner level. Providers who are considered Atypical (not eligible for an NPI) are to submit transactions using their DHS assigned Unique Minnesota Provider Identifier (UMPI) or the Blue Cross proprietary identification number.

To register online or to find the NPI paper application form, access the CMS website at <http://nppes.cms.hhs.gov>.

It is a provider's responsibility to report its NPI to payers. To access the NPI submission instructions, go to bluecrossmn.com for health care providers, HIPAA/NPI Compliance.

Credentialing

Overview

Blue Cross and Blue Shield of Minnesota uses a credentialing process to provide Subscribers with a selection of Providers and Health Care Professionals which have demonstrated backgrounds consistent with the delivery of high quality, cost-effective health care. The credentialing criteria that Blue Cross has established serve as the foundation for determining eligibility in all Blue Cross networks. Providers and Health Care Professionals are expected to remain in compliance with credentialing criteria at all times.

Credentialing Requirements and Processes

To learn more about credentialing requirements and processes, please reference the Credentialing and Recredentialing Policy Manual, available at bluecrossmn.com. Credentialing requirements include, but are not limited to the following:

- Blue Cross may require credentialing no less than every three years. Recredentialing may occur as often as Blue Cross determines necessary. Providers may appeal adverse credentialing or recredentialing decisions through Blue Cross' established appeal process as specified in the Credentialing and Recredentialing Policy Manual.
- In the event one or more of Provider's Health Care Professionals are excluded from participation with Blue Cross, because he or she has not met the credentialing standards of Blue Cross or because Blue Cross has terminated or suspended the Health Care Professional as provided for in the Agreement, that Health Care Professional will be treated as a nonparticipating provider by Blue Cross. Provider agrees to provide prior written notice to any Subscriber receiving treatment from such Health Care Professional that he or she is nonparticipating. If such notice is not provided, neither Provider nor Provider's nonparticipating Health Care Professional may collect from the Subscriber more than the amount allowed by Blue Cross. Provider further agrees to be responsible for any applicable nonparticipating penalty payments required in Subscriber Contracts and to hold Subscriber harmless for these payments in such circumstances. Either the affected Health Care Professional or the Provider, on behalf of the affected Health Care Professional, may appeal a suspension or for cause termination as specified in the Blue Cross Credentialing and Recredentialing Policy Manual. This provision shall survive termination of this Agreement.

Credentialing Requirements and Processes (continued)

- Some participating Health Care Professionals are exempt from Blue Cross' credentialing and recredentialing process unless a potential quality of care issue arises, at which time Blue Cross will undertake a standard credentialing or recredentialing process. In all cases, Provider is responsible for verification that Health Care Professionals hold and maintain (a) a current and unrestricted license, registration, or certification appropriate to their practice; and (b) minimum malpractice coverage as detailed in the Provider Service Agreement and Credentialing Policy and Procedure Manual and to the extent the Health Care Professional is covered by a state or federal Tort Claim Liability statute. The Credentialing and Recredentialing Policy Manual contains a listing of Health Care Professional specialties for which credentialing is required. All Providers are subject to all federal and state statutes regarding licensure and credentialing including, but not limited to, Minnesota Statutes 62Q.121 and 245A.192.

Sanctions, Reprimands or Investigations

Blue Cross reserves the right to terminate the Provider Service Agreement upon 30 days' prior written notice to Provider with respect to any Provider or Health Care Professional of a Provider or a physician who assumes responsibility for overseeing or administering any medical services performed by the Provider who fails to complete the credentialing or recredentialing process or is sanctioned or reprimanded by any review organization, including but not limited to, any other health insurer or Health Plan, peer review organization, hospital medical staff or any state licensing board. Providers must immediately notify Blue Cross in writing of any such sanction or reprimand or any investigation of any Provider or Health Care Professional or Medical Director of which Provider is aware. If the sanction or reprimand is limited to a single Health Care Professional, then the termination shall be effective only to that Health Care Professional.

Questions about Credentialing

Call provider services at **(651) 662-5200** or **1-800-262-0820**.

Accounting for Disclosure Request

Guidelines for the Accounting Disclosure Request

Blue Cross Subscribers have the right to an accounting of certain disclosures that are made of their protected health information (PHI) within six years prior to their request. Blue Cross will fulfill these requests with a Subscriber disclosure summary. Providers are requested to follow the guidelines listed below and forward required disclosures to:

Blue Cross and Blue Shield of Minnesota and Blue Plus
Attention: Compliance and Regulatory Affairs
P.O. Box 64560
St. Paul, MN 55164-0560

When to Use the Form

If a disclosure is subject to an accounting, Providers must use the Business Associate Accounting for Disclosures Report Form, available at bluecrossmn.com under forms: member. Disclosures which require an accounting include disclosures which are made:

1. pursuant to applicable law;
2. for cadaveric organ donation purposes;
3. to avert a serious threat to health or safety;
4. for certain marketing or fundraising exceptions; and
5. to the Secretary of Health and Human Services.

The form provides a more detailed list of those disclosures that must be accounted for. Not all disclosures of an individual's PHI are subject to an accounting.

Providers are not required to account for disclosures they make:

- before the privacy rules compliance date (April 14, 2003)
- to the individual
- to or for notification of persons involved in an individual's care
- for treatment, payment, or health care operations
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials regarding inmates
- for research if it involves at least 50 records and we provide individuals with a list of all the research protocols and the researcher's name and contact information
- using de-identified health information

Disclosures Related to Provider's Status as a Business Associate

The Provider Service Agreement requires Provider to account for only those disclosures of records that it holds in its capacity as a business associate. Provider is Blue Cross' business associate because the Provider Service Agreement requires Provider to perform certain activities on Blue Cross' behalf. These business associate activities are:

- Compliance with and implementation of quality improvement/managed care requirements such as providing specific patient records for a quality study; and
- Receiving and resolving Subscriber complaints.

Thus, for example, if Provider reports a complaint to Blue Cross as required by the Provider Service Agreement, Provider is gathering that information and forwarding it to Blue Cross as a business associate. Provider does not have to report the disclosure to Blue Cross because it is part of health care operations. If, however, a regulator was to audit Blue Cross' compliance with handling Subscriber complaints, Provider must release correspondence or records to the regulator, as this is a disclosure Provider must account for. Another example would be records that Provider provided to Blue Cross for Child and Teen Checkups. If the Department of Health were to decide to monitor managed care plans for child and teen checkups, they may ask for all the information Provider provided to Blue Cross as part of the on-site audits. The disclosure is permitted to the Department of Health without authorization as a public health activity, but it must be accounted for.

Provider does not have to account for disclosure of records that it has in its capacity as a provider. For example, as discussed above, Provider might have medical records from providing a teen with a checkup. Subsequently, the teen is involved in a crime and the medical records are necessary for identification purposes. Provider may disclose the medical record to law enforcement authorities and must account to the teen for that disclosure. Provider does not, however, have to account to Blue Cross for that disclosure.

Carrier Replacement Law

Carrier Replacement The Law

The Minnesota Carrier Replacement Law applies when a Subscriber group terminates its fully insured coverage with one carrier and replaces it with another fully insured group contract. This law dictates how Blue Cross determines liability for charges incurred by a Subscriber whose inpatient treatment occurred during this change in coverage.

How Carrier Replacement Works

- The carrier whose coverage is in effect when a Subscriber is admitted to a facility is liable for all institutional charges incurred by the Subscriber whose inpatient treatment spans the change in coverage.
- The carrier in effect at the time of admission is liable for all professional charges incurred up to the termination date of the coverage.
- The new carrier is liable for all professional charges incurred beginning on the effective date of the new coverage.
- The definition of “discharge” is the date the Subscriber is formally released from the inpatient facility with discharge papers completed.

Continuous Stay

Continuous stay occurs when the Subscriber is sent to another facility for services unavailable at the current facility and no discharge or admission papers are processed upon transfer.

- In the case of a Subscriber who is discharged and transferred to another facility, both the transportation and charges incurred at the new facility will become the liability of the new carrier.

When...	Then...
<p>a new Subscriber was hospitalized prior to the effective date of Blue Cross coverage</p> <p>a new Subscriber remains hospitalized on and after the first date of coverage</p> <p>the new Subscriber's other carrier stops paying for the hospitalization or there is no other carrier</p>	<p>Blue Cross pays the hospital claim on a pro rata basis beginning on the date coverage becomes effective.</p>

Public Programs

DHS requires the Health Plan active at the time of Subscriber admission to an inpatient facility to be responsible for approved facility charges for the inpatient stay until the discharge date. Professional charges are the responsibility of the plan in effect for the applicable date of service.

- All professional services occurring after the termination date of the Subscriber's eligibility with Blue Plus are denied as "Member Termination".
- If a member becomes eligible for Blue Plus during an inpatient stay, facility charges will deny as "no coverage". Professional claim eligibility will be determined based upon the member's effective date with the plan for those dates of service.
- Medicare supplement contracts will cover the Medicare inpatient deductible. However, Medicare Coinsurance Days are denied after the coverage termination.

Federal Employee Program

When Federal Employee Health Benefits coverage ends, the employee and eligible dependents may receive an additional 31 days of coverage, for additional premium, when:

- enrollment ends, unless the employee cancels their enrollment or
- the employee family members are no longer eligible

The employee may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy.

InstaCareSM

This Contract terminates at the end of the contract term selected on the Contract Schedule and Application, except in instances where the Subscriber or their covered dependents are confined to a hospital on that date. For that person, we will extend the contract term only for the condition causing the hospital confinement. The extension will end when the person is no longer confined to the hospital or when the lifetime maximum has been paid, whichever occurs first.

Self-funded Groups and Minnesota Advantage Health Plan

Carrier Replacement law does not apply to self-insured business.

Governmental and Compliance Required Provisions

<p>Overview</p>	<p>Federal and state governmental agencies require Health Plans, such as Blue Cross, to inform providers of certain information. Additional requirements are also necessary for accreditation and other quality compliance.</p>
<p>Governmental Required Definitions</p>	<ul style="list-style-type: none"> • "Managing Employee" means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or any part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or any part thereof, as defined in 42 C.F.R. Section 455.101. • "Medicare Advantage" means Medicare Advantage programs as defined by Centers for Medicare and Medicaid (CMS), where Blue Cross is the payor for health services provided to Medicare Subscribers. • "Medicare Advantage Special Needs Plan" means a Medicare Advantage program as defined by CMS under which Blue Cross is the payor for health services provided to Medicare Subscribers with special needs. An example of such a plan is Minnesota Senior Health Options (MSHO). • "Minnesota Health Care Programs" means prepaid public programs including Medical Assistance, MinnesotaCare, Families and Children or other prepaid public programs in which Blue Plus provides coverage under a contract with any Minnesota County or with the Minnesota Department of Human Services (DHS). Participating provider's agreements apply to Health Services provided to Minnesota Health Care Program Subscribers where applicable. • "Minnesota Senior Health Options" (MSHO) means the Minnesota prepaid managed care program, pursuant to Minnesota Statutes, Section 256B.69, subd. 23, that provides integrated Medicare and Medicaid services for Medicaid eligible seniors, age sixty-five (65) and over. MSHO includes Elderly Waiver services for enrollees who qualify, and one hundred eighty (180) days of nursing facility care. • "Person with an Ownership or Control Interest" means a person or corporation that (1) has an ownership interest, directly or indirectly, totaling five percent or more in Blue Cross or a disclosing entity; (2) has a combination of direct and indirect ownership interests equal to five percent or more in Blue Cross or a disclosing entity; (3) owns an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by Blue Cross or a disclosing entity, if that interest equals at least five percent of the value of the property or assets of Blue Cross or a disclosing entity; or (4) is an officer or director of Blue Cross or a disclosing entity (if it is organized as a corporation) or is a partner in Blue Cross or a disclosing entity (if it is organized as a partnership).

Compliance with Laws

In order to have a Provider Service Agreement with Blue Cross, Providers and Blue Cross are required to abide by all applicable state and federal laws, rules, regulations, orders and requirements that are related to providing health care and billing for health care.

- **Cooperation with Blue Cross.**

In addition to complying with all state and federal laws, rules, regulations, orders and requirements, Provider further agrees to cooperate with Blue Cross in its efforts to comply with any and all obligations imposed by state and federal laws, rules, regulations, orders and requirements. This includes 1) promptly notifying Blue Cross in the event the Provider transfers "substantial financial risk" (as defined in 42 C.F.R. Section 422.208) to any of the Health Care Professionals in its employment; and 2) notifying Blue Cross within 20 days of entering into any private contract with a Medicare beneficiary pursuant to Section 1802 of the Social Security Act (such notice to include a copy of the private contract and any other information reasonably requested by Blue Cross).

- **Minnesota Department of Human Services Disclosure Requirements.**

Disclosure of Agreements. Provider must ensure that no agreements exist between itself and an excluded entity or individual for the provision of items or health services under a Provider Service Agreement. Provider shall search the Medicare Exclusion Database (MED) or the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) databases on a monthly basis to insure that no providers, agents, Persons with an Ownership or Control Interest and Managing Employees are (a) excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act, or (b) have been convicted of a criminal offense related to involvement in any program established under Medicare, Medicaid or the Title XX services program. Provider shall notify Blue Cross within five days of identifying any subcontracting individuals or entities listed in (a) or (b) of this paragraph.

- **Minnesota Department of Human Services Enrollment Report**

Providers that provide Health Services to Minnesota Health Care Program Members must enroll with the Minnesota Department of Human Services (DHS). DHS provides the DHS provider enrollment report to Blue Cross. Blue Cross uses the DHS provider enrollment report to determine if a provider that is contracted with Blue Cross and providing Health Services to Minnesota Health Care Program Members is on the DHS provider enrollment report as required. Blue Cross continuously monitors the DHS provider enrollment reports. Blue Cross has the right to terminate contracts with providers that provide Health Services to Minnesota Health Care Program Members but do not enroll with DHS as required.

Effective July 17, 2023, the [21st Century Cures Act](#) requires states to enroll **all** Medicaid providers, both those in Medicaid fee-for-service (FFS) and those in managed care organization (MCOs) networks.

- **Providers can enroll with DHS by following this link:**

[DHS Enrollment](#)

Compliance with Laws (continued)

- **Disclosure of Ownership Information.** To assure compliance with 42 C.F.R. Section 438.610, Provider shall report the following information to Blue Cross prior to the effective date of the Agreement: (a) the name and address of each Person with an Ownership or Control Interest in a disclosing entity or in any subcontractor in which a disclosing entity has direct or indirect ownership of five percent or more; and (b) a statement as to whether any Person with Ownership or Control Interest is related to any other Person with an Ownership or Control Interest, listed in section (a) as a spouse, parent, child or sibling; and (c) the name of any other organization in which a Person with an Ownership or Control Interest in a disclosing entity also has Ownership or Control Interest. The Disclosure of Ownership form is available at <https://www.bluecrossmn.com/providers/forms-and-publications> (enter “Disclosure of Ownership and Management Information Form” in the Search bar).
- **Advance Directives.** Provider must make information available to Subscribers to aid them in completing advance directives, including but not limited to helping them to understand medical terminology, medical care options and referring them to appropriate resources such as the Minnesota Department of Health Website. Upon a Subscriber's request, Provider must maintain a copy of a Subscriber's advance directive in the medical record maintained by Provider.
- **CMS Regulations Regarding Subcontracting.** As set forth in 42 C.F.R. Sections 422.504 and 422.505, Provider must comply with all Medicare statutes and regulations and CMS requirements as interpreted and applied by the CMS designated regional office and the CMS central office, including but not limited to Medicare Offshore Subcontracting Attestation and other requirements relating to activities performed outside the United States. Upon request, Provider must submit record of such compliance to Blue Cross. In addition, Medicaid payments must not be made (1) for services delivered or items supplied outside of the United States; or (2) to a provider, financial institution, or entity (including subcontractors) located outside of the United States. For purposes of compliance with this rule, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Items and services provided under a state plan that would be prohibited offshore can include but are not limited to telemedicine, pharmacy, and other services from providers.

Compliance with Laws (continued)

- **Cultural Competency Training and Accessibility Requirements.** In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Section 438.10 of the Managed Care Federal Regulation issued on May 6, 2016, requires that providers who provide health care services to MHCP members enrolled in a Managed Care Organization (MCO) annually confirm compliance with the requirement of cultural competency training and accessibility for people with disabilities. Therefore, providers must promptly complete and return an annual Blue Cross Provider Directory Questionnaire for all their provider locations for Cultural Competency Training and Accessibility. The questionnaire is located on the Blue Cross website at: [www/bluecrossmn.com](http://www.bluecrossmn.com)
- **Home Health Care Bill of Rights Requirement.** Home Health Care providers are required to provide the Subscriber or the Subscriber's representative with written notice of the Home Care Bill of Rights prior to the date that services are first provided to that Subscriber.

The provider shall make all reasonable efforts to provide notice of the rights to the Subscriber or the Subscriber's representative in a language the Subscriber or Subscriber's representative can understand.

The Home Care Bill of Rights is available on the Minnesota Department of Health website (www.health.state.mn.us) under the Facility Certification, Regulation and Licensing section, and is available in several languages.

- [Patient, Resident and Home Care Bill of Rights - MN Dept. of Health \(state.mn.us\)](http://www.health.state.mn.us/patient-resident-home-care-bill-of-rights)

In addition, DHS recommends that Home Care providers provide the Home Care Bill of Rights to Subscribers at least 30 days before terminating a Subscriber's services.

**HIPAA
Requirements**

HIPAA Compliance. Pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") that are applicable to business associates, Provider agrees that it shall:

- Not use or further disclose Protected Health Information (PHI) other than as permitted or required by the Provider Service Agreement between Blue Cross and Provider, and further agrees that it shall not use or further disclose PHI in a manner that would violate requirements of HIPAA and its implementing regulations (45 C.F.R. parts 160-64) ("HIPAA Regulations") or the HITECH Act;
- Report to Blue Cross any use or disclosure of PHI not provided for by the Provider Service Agreement of which it becomes aware, within five (5) days after such discovery, and ensure that any agents, including any subcontractors, to whom it provides to or receives from PHI, agree to the same restrictions and conditions that apply to Provider with respect to such information;
- Upon any termination of the Provider Service Agreement, extend the protections of this Section to any PHI in the possession of Provider, and limit any further use and disclosure of such PHI to those purposes set forth in the Provider Service Agreement;

**HIPAA
Requirements
(continued)**

- Develop, implement, maintain and use appropriate administrative, technical and physical safeguards, in compliance with Social Security Act Sec. 1173(d) (42 U.S.C. Sec. 1320d-2(d)), 45 C.F.R. Sec. 164.530(c)) and any other implementing regulations issued by the U.S. Department of Health and Human Services;
- Upon receipt of notice from Blue Cross, promptly amend or permit Blue Cross access to amend any portion of the PHI which the provider created or received from Blue Cross so that Blue Cross may meet its amendment obligations under 45 C.F.R. Sec. 164.526;
- Comply with all applicable federal laws, including, but not limited to 42 C.F.R. Part 2, governing confidentiality for people seeking treatment for substance abuse disorders from federally assisted programs, as well as all state laws not preempted pursuant to 45 C.F.R. Part 160, subpart B.
- With the exception of disclosures of PHI made for the purposes specified in 45 C.F.R 164.528(a)(1)(i)-(ix), document and report each disclosure, if any, the provider makes of any PHI Provider has created for Blue Cross or received from Blue Cross within five (5) days of the discovery of the disclosure. The provider shall cooperate with Blue Cross in investigating the disclosure and in meeting Blue Cross' obligations under the HIPAA regulations and HITECH Act. In the event of any such disclosure, the provider shall:
 - Identify the nature of the non-permitted access, use or disclosure, including the date of the breach and the date of discovery of the breach;
 - Identify the PHI accessed, used or disclosed as part of the breach (e.g. full name, social security number, date of birth etc.);
 - Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;
 - Identify what corrective action the provider took or will take to prevent further non-permitted access, uses or disclosures;

HIPAA Requirements (continued)

- Identify what the provider did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and
- Provide such other information, including a written report, as Blue Cross may reasonably request.

Provider acknowledges and agrees that in the event the Provider breaches this HIPAA requirements, Blue Cross may terminate the Provider Service Agreement upon written notice to the Provider and/or report such breach by the Provider to the United States Department of Health and Human Services.

HIPAA Security. The Provider agrees to the following:

- The Provider shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information ("e-PHI") that it creates, receives, maintains or transmits on behalf of Blue Cross, as required by 45 C.F.R. Part 164 (the "Security Rules").
- To ensure that any agent, including a subcontractor to whom it provides e-PHI agrees to implement reasonable and appropriate safeguards to protect it, and
- To report to Blue Cross any security incident involving e-PHI of which it becomes aware. The Security Rules define a "Security Incident" as an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, involving e-PHI that is created, received, maintained or transmitted by or on behalf of Provider or Blue Cross. Since the Security Rules include attempted unauthorized access, use, disclosure, modification or destruction of information, Blue Cross needs to have notification of attempts to bypass electronic security mechanisms. Provider and Blue Cross recognize and agree that the significant number of meaningless attempts to, without authorization, access use, disclose, modify, or destroy e-PHI will make a real-time reporting requirement formidable for Provider. Therefore, Provider and Blue Cross agree to the following reporting procedures: Security Incidents that result in unauthorized access, use, disclosure, modifications or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

**HIPAA
Requirements
(continued)**

For Unsuccessful Security Incidents, Provider and Blue Cross agree that this paragraph constitutes notice of such Unsuccessful Security Incidents. By way of example, Provider and Blue Cross consider the following to be illustrative of Unsuccessful Security Incidents when they do not result in actual unauthorized access, use disclosure, modification or destruction of e-PHI or interference with an information system:

- Pings on the Provider's firewall.
- Port scans.
- Attempts to log onto a system or enter a database with an invalid password or username.
- Denial-of-service attacks that do not result in a server being taken off-line.
- Malware (worms, viruses, etc.).

For Successful Security Incidents, the Provider shall give notice to Blue Cross not more than five (5) business days after learning of the Successful Security Incident

Provider acknowledges and agrees to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH Act as detailed at:

[HITECH Act Enforcement Interim Final Rule](#)

Non-interference	<p>Provider agrees not to interfere in the business relationships of Blue Cross with its group purchasers, Subscribers, Plan Sponsors or other providers by discouraging or attempting to discourage group purchasers, Subscribers, Plan Sponsors, or other providers from initiating or maintaining their business relationship with Blue Cross. This provision does not prohibit normal business activities such as participation in other Health Plans. This provision prohibits Provider activity such as disclosing proprietary information, for example specific financial or other terms of the Provider Service Agreement (as well as specific financial information relating to any other agreement between a provider and Blue Cross), unless otherwise expressly authorized by Blue Cross in writing signed by an officer of Blue Cross or as required by law. This provision also prohibits the Provider from defaming Blue Cross for financial or participation purposes, including but not limited to attempting to collect payments from group purchasers, or suggesting other providers, group purchasers, Subscribers or Plan Sponsors terminate their relationship with Blue Cross. This provision is not intended to interfere with the provider-patient relationship or prohibit the Provider from communicating with Subscribers as provided by Minnesota Statutes Section 62J.71. Blue Cross encourages and permits open communication between the Provider and the patient regarding treatment options available to the patient regardless of benefit coverage limitations. Benefit coverage is always governed by the terms of the Subscriber Contract. Blue Cross similarly agrees not to interfere in the business relationships of the Provider with its group purchasers or other providers. This provision does not preclude Provider from adhering to network participation guidelines and requirements.</p>
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<p>Network Access Agreements</p>	<p>In addition to providing Health Services to Subscribers enrolled in health benefit plans underwritten or administered by Blue Cross, the Provider Service Agreement applies to health services provided in the following instances:</p> <ul style="list-style-type: none"> • Health Services provided to Subscribers for whom Blue Cross or its Affiliates provides access to a Blue Cross participating provider network, where no administrative or claims payment services are provided and neither Blue Cross nor its affiliates assume any financial risk or obligation with respect to claims. In all such network access arrangements, Blue Cross shall ensure that (a) Subscribers are directed to receive Health Services from a provider through benefit differentials outlined in the Subscriber Contract, (b) Subscribers are required to produce a membership card that identifies him/her as a Subscriber who is entitled to use the participating provider network, (c) the application of the Blue Cross fee schedule is clearly listed on the explanation of benefits furnished to the Subscriber, and (d) that the entity which has contracted with Blue Cross for access to the participating provider network agrees to comply with the prompt payment/prompt response provisions of the Provider Service Agreement. Blue Cross shall notify Provider of such network access arrangements and furnish information regarding any special requirements for the applicable Subscriber's contract.
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Clarifying Definitions for Quality Incentive and Gain/Risk Share Payment

Definitions

Unless the context requires otherwise, the following definitions importing the singular number shall include the plural and vice versa.

- **“ACO Product”** means a health insurance product that features a particular participating provider as the preferred provider option within the product’s network and for which Blue Cross and the featured participating provider share in the risk of the product’s financial performance.
- **“Change in Control”** means the following, in a single or related series of transactions: the consolidation or merger of Provider with or into any person or entity (other than the consolidation or merger of Provider with an existing Affiliate of Provider in which Provider is the surviving entity of such consolidation or merger); the sale, transfer or other disposition of all or substantially all of the assets of Provider; and/or the acquisition by, or transfer to, any person or entity, or group of persons or entities acting in concert, of any legal, beneficial, equitable and/or other interest in securities, member interests, membership interests, voting interests and/or other interests, representing (a) at least fifty percent (50%) of the issued and outstanding securities, member interests, membership interests, voting interests and/or other interests of Provider, or (b) the right to elect or appoint a majority of the governing board of (i) Provider, or (ii) any person or entity that directly, or indirectly through one or more intermediaries has the right to elect or appoint a majority of the governing board of Provider.

**Definitions
(continued)**

- **“Clinic Visit”** means a visit at which any covered Health Services are provided to a Blue Cross Member that has not been admitted to a hospital and is receiving care in an office, outpatient hospital setting, or other facility listed below and for which claims are submitted to Blue Cross on one or more claim forms 837P. For purposes of clarification (a) office, outpatient hospital settings, and other applicable facilities are defined by the place of service codes, which are currently 02 (Telehealth-other than patient’s home), 10 (Telehealth-In Home), 11 (Office), 12 (Home Health), 13 (Assisted Living Facility), 19 (Off Campus-Outpatient Hospital), or 22 (Hospital Outpatient), 31 (Skilled Nursing Facility), 32 (Nursing Facility), 33 (Custodial Care Facility), 50 (Federally Qualified Health Center), 71 (Public Health Clinics) and 72 (Rural Health Clinic), respectively, as defined and modified from time to time in the Current Procedural Terminology published by the American Medical Association; (b) there is no requirement for an Evaluation and Management Services CPT Code for covered Health Services to be considered a Clinic Visit and (c) care coordination visits billed with CPT code T1016 are excluded.
- **“Johns Hopkins’ Adjusted Clinical Groups Methodology” or “Johns Hopkins’ ACG Methodology”** means the methodology for measuring the morbidity burden of patient populations based on disease patterns, age, and gender as described in the Johns Hopkins’ white paper entitled “The Johns Hopkins ACG® System.”
- **“Medical Expenses”** means the sum of the Paid Amount of all claims for Health Services incurred by Provider Attributed Members during a calendar year in which this Addendum remains in effect and which claims are Adjudicated no later than the first eight months of the following year.

**Definitions
(continued)**

- **“Risk-Adjusted Using Johns Hopkins’ ACG Methodology”** means using the retrospective risk score (normalized by dividing Provider’s risk score by Blue Cross’ network average risk score (“Provider’s normalized risk score”)) to adjust for risk, determined as described in Johns Hopkins’ ACG Methodology as implemented by Blue Cross.
- **“Paid Amount”** for a participating provider means an amount that a participating provider has agreed to accept as full payment for a claim for a Health Service less Member or other party liabilities (e.g. deductible, coinsurance, non-covered services, and coordination of benefits with other health plans, employer liability plans, Workers’ Compensation, or automobile plans) collectively “Other Party Liabilities.” “Paid Amount” for a nonparticipating provider for purposes of Blue Cross value-based agreements means an amount determined by Blue Cross or subcontracted vendor or administrator, including any amounts to be paid by a Blue Cross Member to cover the amount of a nonparticipating provider’s charges for a claim for a Health Service less Member or Other Party Liabilities
- **“PMPM”** means per Blue Cross Member, per month.
- **“Primary Care Health Care Clinic”** means the aggregation of Primary Care Health Care Professional(s) practicing in a clinic or facility and used in attributing Members to Provider or to an unrelated third-party provider, respectively.
- **“Primary Care Health Care Professional”** means physicians, certified nurse midwives, clinical nurse specialists, physician assistants and nurse practitioners who are engaged in providing Primary Care Services.
- **“Primary Care Services”** means a clinic visit rendered by (i) a physician with a Blue Cross primary specialty designation of general practice, family practice, geriatric, internal medicine, OB/GYN, or pediatrics, other than a physician who exclusively practices in a non-clinic facility setting; or (ii) a certified nurse midwife, clinical nurse specialist, nurse practitioner or physician assistant, other than a certified nurse midwife, clinical nurse specialist, nurse practitioner, or physician assistant who exclusively practices in a non-clinic facility setting; if the clinic visit is billed by a clinic with a Blue Cross specialty designation of primary care, multi-specialty, nurse practitioner or physician assistant.

**Definitions
(continued)**

- **“Provider Attributed Member”** means each Blue Cross Member who meets the following criteria within the program type:

Commercial:

- (a) has 273 or more non-consecutive calendar days of coverage with Blue Cross during the applicable calendar year, and
- (b) is at least one year of age and less than sixty-five years of age at the end of the applicable calendar year, and

Minnesota Health Care Programs (MHCP):

- (a) has 181 or more consecutive calendar days of coverage or nine or more non-consecutive months with Blue Plus during the applicable calendar year with three (3) months runout, and
- (b) is less than sixty-five (65) years of age at the end of the applicable calendar year, and

Minnesota Senior Health Options (MSHO):

- (a) has one or more consecutive calendar days of coverage with Blue Plus during the applicable calendar year with three (3) months runout, and
- (b) is greater than or equal to sixty-five (65) years of age at the end of the applicable calendar year, and

Medicare Advantage:

- (a) has one or more consecutive calendar days of coverage with Blue Cross during the applicable calendar year with three (3) months runout, and

All:

- (b/c) has incurred the greatest number of such Member's Clinic Visits during the applicable calendar year with one or more Primary Care Health Care Clinic Of Provider, as determined by Blue Plus/Blue Cross.

If Members do not attribute to a Primary Care Health Care Clinic of any provider but do have at least two Clinic Visits by a cardiologist, nephrologist or oncologist, the Member will also attribute to Provider.

- **“Provider Attributed Member Months”** means the aggregate number of months in a calendar year in which Blue Cross Members are Provider Attributed Members.

Termination of Provider Service Agreements

Required Notification

A Provider Service Agreement may be terminated according to any one or more of the following provisions. Termination determinations are not subject to appeal. Providers must send a termination request in writing via certified mail to Blue Cross, directed to: Blue Cross and Blue Shield of Minnesota, Attn: Provider Relations, R317, P.O. Box 64560, St. Paul, Minnesota 55164-0560.

- Without cause by either Party upon prior written notice to the other Party with termination to become effective 130 days after receipt of written notice. If the Agreement is so terminated, Blue Cross, at its discretion, may extend the terms of the current Agreement for a period of up to an additional 180 days, to allow Blue Cross proper notification to Subscribers and continuity of care practices. During such additional period of 180 days of participation, the Provider shall receive payment at the same rates that were in effect on the date termination notification was provided.
- By a Party upon prior written notice to the other Party in the event of a material breach of the Provider Service Agreement by such other Party and which breach remains uncured 30 days after written notice reasonably specifying the nature of the breach is given to the breaching Party, with termination to become effective on the 30th day after receipt of such written notice.
- Immediately upon written notice by Blue Cross to Provider in the event that Blue Cross acquires evidence of the potential for patient harm or of suspected fraudulent or illegal conduct on the part of Provider or any of Provider's Health Care Professionals with regard to the practice of medicine, claim submission, Health Care Professional eligibility, the delivery of care under the Provider Service Agreement, or in the event of any sanction (1) by CMS under the Medicare program; or (2) by the Minnesota Department of Human Services under a Minnesota Health Care Program.

**Required Notification
(continued)**

- By Blue Cross upon 30 days' prior written notice to Provider with respect to any Provider or Health Care Professional of Provider which fails to complete the credentialing or recredentialing process or is sanctioned or reprimanded by any review organization, including but not limited to, any other health insurer or Health Plan, peer review organization, hospital medical staff or any state licensing board. The Provider agrees to immediately notify Blue Cross in writing of any such sanction or reprimand or any investigation of any Provider or Health Care Professional of which Provider is aware. If the sanction or reprimand is limited to a single Health Care Professional, then the termination shall be effective as to that Health Care Professional only.
- By Blue Cross of Provider's participation in benefit plans (including but not limited to the Minnesota Advantage Health Plan, political subdivisions, and Workers' Compensation) if Provider is determined by DHS to be out of compliance with Minnesota Statutes, Section 256B.0644 (requiring providers to accept medical assistance patients) or any other applicable laws. Provider shall notify Blue Cross immediately in event of such non-compliance. The termination shall be effective as of the first date of such non-compliance.
- In the event that Blue Cross does not receive any claims submitted by Provider for a 12-month period, Blue Cross will terminate the agreement upon the expiration of that 12-month period.
- If Provider plans to relocate its practice outside of the contracting service area, Provider must immediately notify Blue Cross of such plans, and Blue Cross shall terminate the Agreement effective upon the date of the relocation, with prior written notice to Provider. If such change of address has occurred and Provider failed to notify Blue Cross, Blue Cross shall immediately terminate the Agreement.
- For Minnesota Advantage Health Plan Subscribers and Federal Employee Plan Subscribers only, if the Agreement terminates during the calendar year, all the terms of the Agreement will continue until the end of the current calendar year.
- By Blue Cross upon 30 days' notice to Blue Cross of Provider's addition to the CMS Preclusion List.
- In the event of a Provider acquisition or expansion, Blue Cross shall in its sole discretion, determine if a participating agreement will be extended to the acquired entity and/or additional locations of Provider.

Chapter 3

Quality Improvement

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Introduction to Quality Improvement

General Overview

This chapter contains detailed information about the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Quality Improvement (QI) program and Practitioner/Provider requirements. Some requirements for Behavioral Health Practitioner/Providers are different than this section. Requirements that are different or more stringent for Behavioral Health Practitioner/Providers are detailed in the Quality Improvement for Behavioral Health Practitioner/Providers section. The material also explains what is expected from participating Practitioner/Providers regarding their quality programs and defines Practitioner/Provider requirements including medical record keeping practices.

The QI program helps to ensure access to healthcare services using established quality improvement principles. Blue Cross utilizes the Quality Improvement program to:

- Identify gaps of care or accessibility.
- Develop clinical guidelines and service standards where clinical performance is measured.
- Monitor and assess the quality and appropriateness of services given to our Members.
- Review medical qualifications of participating health care professionals.
- Enhance Member safety and confidentiality of Members
- Resolve any identified quality issues.

Basic Elements of a QI Program

Rationale:

Blue Cross subscribes to the philosophy of Quality Improvement (QI) and the multifaceted benefits it offers. All Providers associated with Blue Cross networks must include quality improvement activities in their facilities. Striving to meet or exceed customer expectations should be a driver for a successful program. A well-established program enables Provider to discover root causes, use data to increase production, and maximize available resources. A successful program has three basic elements: it must be customer-focused, data-driven, and process-oriented.

Basic Elements of a QI Program, continued

Blue Cross supports the six aims for improvement identified in the Institute of Medicine's *Crossing the Quality Chasm*. These six aims are that care should be safe, effective, patient-centered, timely, efficient, and equitable. All Blue Cross Providers are expected to incorporate these aims into their Quality Improvement programs.

Several models are available to guide and direct QI project efforts. Examples of these models include the Plan, Do, Check, Act (PDCA) Cycle, Six Sigma, Lean Thinking and the Seven-Step Process.

Requirements:

- Provide annual QI program report upon request to Blue Cross.

Leadership

Rationale:

Leadership within an organization must support and embrace the philosophy of Quality Improvement for it to succeed. Advising, supporting, and actively participating in the development and implementation of process improvement is a vital function of leadership.

Improving processes within an organization promotes better care and services to customers, creating a marketplace advantage.

Requirement:

- Designated QI Medical Director, who is a practicing physician and is either a MD or DO.

Quality Improvement Projects

Rationale:

Addressing problems or opportunities within a Provider's location of practice using the QI process offers distinct advantages. Quality Improvement projects employ systematic analysis of current practices to reveal refined approaches to everyday operations. Using a defined model means that changes can be tested and adopted effectively.

Requirements and changes regarding QI reporting are distributed annually in the first quarter to all main site primary care providers.

Suggested project categories may include clinical guideline implementation or improvement, administrative or process-oriented improvements, or improvements based on customer feedback.

Quality Improvement Projects, continued

Often Providers choose to do one project that is clinical and one that is service-related. Blue Cross encourages Providers to conduct a survey or focus group of customers as it develops system changes. Projects may focus on primary care, the continuity of care within a system (from specialty care or hospital care back to primary care) or on specialty care.

Blue Cross does not routinely collect project information from Providers however, requirements remain the same. The requirements listed below should be followed if the Provider's location of practice chooses to implement improvement activities.

Requirements:

- Provide QI program description, contact information, or project reports upon request.
- Clinical projects must be based on approved and established guidelines [i.e., Institute for Clinical Systems Improvement (ICSI)].
- Projects have completed a full PDCA Cycle or Seven-Step process. Refer to the PDCA or Seven-Step Process information.

Cooperation with Blue Cross QI Program

Rationale:

Collaborative efforts need to mutually service Blue Cross' Members with excellent care and services.

Requirements:

- Quick access to medical records when requested.
- Consultation and cooperation to resolve individual Member complaints.
- Timely responses to queries during quality of care investigations.
- Participation in quality audits, including site visits and medical record standard reviews and Healthcare effectiveness data and information sharing Set (HEDIS) record review.
- Participate in other Blue Cross QI work, this may require additional information from Providers or participation in survey's.
- Collaborate on corrective action plan when Blue Cross quality thresholds are not met.

**Telephone Service
Requirements: During
Office Hours**

Rationale:

Members need telephone access to medical care with a response time based on the urgency of their symptoms.

Requirements:

During office hours, Members calling a Practitioner/Provider will be assessed according to Member's care needs by a physician or designee. Response times are applicable to all members regardless of product type or plan:

- Immediately for emergencies, 100% of the time.
- Within 30 minutes for urgent issues, 85% of the time.
- Within 4 hours for all other call types, 85% of the time.

**Telephone Service
Requirements: In-
coming Calls**

Rationale:

A timely response to incoming phone calls promotes Member satisfaction.

Requirements:

- Calls answered in six rings or fewer.
- On hold two minutes or less.

**Telephone Service
Requirements:
After Hours**

Rationale:

Members must have access to instructions for obtaining care 24 hours a day, 7 days a week, and 365 days a year. When Members call Practitioner/Provider's location of practice outside of routine business hours, it is important that they are able to receive directions on how to obtain care and get answers to their questions.

Requirements:

To achieve this, Practitioner/Providers must have a telephone number that is answered 24 hours a day by either a live person, or an answering system that will provide Members information as outlined below.

- The name of the clinic that the Member is calling is clearly stated.
- Specific instructions on what the Member should do if they feel their situation is a medical emergency. This is often stated, "If you feel this is a medical emergency please hang up and dial 911."
- Information regarding who the Member should call if it is not a medical emergency, but feel they need medical advice. Be certain to include the name, area code and telephone number of the individual or clinic to whom they are being directed.
- If the Member is directed to leave a message, Practitioner/Providers have standards for maximum allowable call-back times based on what is medically appropriate to each situation. Blue Cross recommends that Practitioner/Providers call their patients back within two hours. Time frame must be provided to the patient awaiting the return call.
- All instructions should be articulated slowly and clearly in terms understandable to non-health care professionals.

Additional tips:

- If an electronic answering system is being used to create a message, minimize excess background noise and make sure the recording volume is set to an appropriate level.
- If the Member is being asked to call another location, that location must also have a detailed message or someone answering the phone, to provide the Member instructions for obtaining medical care or advice.
- Blue Cross recommends that Providers audit their messages used outside of normal business hours, according to these guidelines, to make certain they are following the requirements.

Complaint Review System

Rationale:

Member complaints, concerns and grievances reflect their perceptions and expectations. Feedback, whether solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve the quality of care or service. Practitioner/Providers and Blue Cross share a joint commitment to Member satisfaction and to the improvement of care and services delivered to Blue Cross Members.

Requirements:

All Providers will have a policy and procedure in place detailing the following:

- Process to receive written and verbal complaints for Blue Cross Members
- Designate an individual to be the primary contact for complaint management, including the tracking of such complaints
- Document the substance of the complaint, the investigation, and any actions taken
- Primary Care Clinics (PCC) should submit an aggregate quarterly written report to Blue Cross within 30 days after the end of each calendar quarter that includes all complaints, oral and written, received by the clinic. Complaints should be submitted in a report format via the secured e-mail account, Quality.of.Care.Mailbox@bluecrossmn.com
- Submit a quarterly report even if the PCC does not receive any complaints for the quarter
- Notify Members of the right to complain and appeal to their health plan
- Track complaints by categories and report at least annually to an in-house committee.

Complaint Review System, continued

Clarification of terminology:

- **Inquiry** — A formal request for information or education from the patient (e.g., about billing, about a lab test).
- **Complaint** — An oral or written expression of dissatisfaction. All PCCs must receive, investigate and respond to complaints from Blue Cross Members who receive health services at their clinic.
- **Appeal** — A request to change a decision that has already been made. **Blue Cross has the sole accountability to handle appeals.** Direct any Blue Cross Member who requests an appeal to call Blue Cross customer service for assistance. The phone number is on the back of the Member ID card.
- **Grievance** — A term commonly used to describe a request for the clinic to change a decision. A grievance would be considered an appeal by the Member and should be referred to Blue Cross.

Quality of Care Complaints

A quality of care complaint is an additional right of Blue Cross Members. Members may complain if they feel the quality of their care has been compromised. Examples of when Members may file a complaint are:

- They are not receiving an appointment in a reasonable amount of time.
- The PCC is not referring them to a specialist when it is necessary.
- The Practitioner/Provider office was rude or discourteous.
- The Practitioner is unable to diagnose or treat their condition.
- There is a delay in communicating test results.
- Confidentiality or privacy concern.
- Incorrect test ordered or performed.
- Infection control.
- Equipment malfunction, cleanliness.

Blue Cross may supply the Practitioner/Provider with a copy of the Member's complaint and involve the Practitioner/Provider in the solution. Blue Cross is required by Minnesota Statute to acknowledge these complaints within 10 calendar days of receipt; therefore, Blue Cross requires the Practitioner/Provider's expedited attention to any request Blue Cross may have.

Access & Availability**Rationale:**

Members' concept of the quality of care they receive often begins when they make an appointment. Blue Cross also wants to ensure that Members are able to schedule appointments within a timely manner, relative to the services they seek.

Requirements:**Wait Times (Primary Care)**

- **Preventive Care** – within 30 days 85% of the time for well child exam, annual physical exam, etc.
- **Routine Primary Care** – within 7 days 85% of the time for non-urgent symptomatic conditions.
- **Urgent Care** – Same day 85% of the time for medically necessary care which does not meet the definition of emergency care.
- **Emergency Care** – Immediate 100% of the time for immediately life-threatening illnesses, injuries and conditions.
- **After-Hours Care** – Practitioner/Provider instruction should be available 100% of the time. If the Practitioner/Provider requires a Member to leave a message, a return call should be made within 2 hours.

Wait Times (Specialty Care):

- **Routine Care (established patients)** – within 30 days 85% of time.
- **Routine Care (new patients)** – within 30 days 75% of the time.

Member Satisfaction (surveys):

- **Primary Routine Care:** 83% of Members will usually or always be satisfied with when they get a routine care appointment (routine care is when the Member does not need to see a practitioner right away).
- **Primary Urgent Care:** 89% of Members will usually or always be satisfied with when they get an urgent care appointment (urgent care is when the Member needs to see a practitioner right away, for an illness, injury or condition).
- **Specialty Care:** 84% of Members will usually or always be satisfied with when they get a specialty care appointment.

Mechanism for Customer Feedback

Rationale:

Patient feedback is an excellent resource that provides innovative and practical ideas for improving care or service. Analyzing feedback for the purpose of improving processes provides opportunities essential to maintaining customer loyalty.

Patient feedback is collected in a variety of ways. Surveys provide needed information about particular areas, comment cards capture a patient’s thoughts at the time of a visit, focus groups facilitate discussion and external surveys provide comparative statistics.

Requirements:

- Collection and analysis of customer feedback.
- Action on collected feedback through the use of a multi-disciplinary team where appropriate to initiate system change.

Blue Cross conducts a Consumer Assessment of Health Plans (CAHPS) survey to assess Member satisfaction. The CAHPS survey assesses many but not all aspects of a Members satisfaction with his/her practitioner(s) and health plan.

Written Policies

Rationale:

To protect the safety and privacy of all Members, and for the protection of the Provider, Blue Cross requires all Providers to develop and implement written policies and procedures applicable to the services they provide. Providers are encouraged to have policies that are location of practice specific, signed, dated and reviewed annually.

Requirement:

Provider will have policies and procedures in place for the following topics that apply to the services provided in the location of practice.

Policy Required	Recommended Risk Management Elements
Advance Directives	<ul style="list-style-type: none"> • Information made available • Discussion is documented in medical record • Copies retained • Hospitals notified upon admission
Child and Teen Check-ups	<ul style="list-style-type: none"> • Eligibility defined (birth through age 20, MA, PMAP, MNCare children) • Forms for documentation addressed • Age-appropriate services defined • Documentation in medical record • Correct coding

Policy Required	Recommended Risk Management Elements
Communicable Disease Reporting	<ul style="list-style-type: none"> • Requirement to report communicable diseases by State Health Department • Reporting timeframe (within one day) • Responsibility of reporting defined • Forms, completion and submittal addressed
Complaint Management	<ul style="list-style-type: none"> • See Complaint Review System Section
Confidentiality	<ul style="list-style-type: none"> • Training, including how soon initial training occurs, when or how often refresher training occurs, verified by signatures of trainer and individual being trained, and on file for six years • Accountability, including how control is maintained (i.e., who has keys, who is allowed into the location of practice and when) • Protected health information (PHI) disposal • Security of both paper and electronic PHI follow HIPAA guidelines • Reviewed annually
Confidentiality and Security of Medical Records	<ul style="list-style-type: none"> • Refer to the Medical Records section
Foreign Language Translation and Hearing-Impaired Services	<ul style="list-style-type: none"> • Assistance provided for both situations • Interpreter available for phone calls and face-to-face interactions • Members/family are notified that interpreter is provided • Resources are identified
Hazardous Materials and Waste Management	<ul style="list-style-type: none"> • Written plan in place and maintained • Hazardous material and waste defined • Mechanism in place for responding to a spill • MSDS (material safety data sheets) available • Hazardous materials and waste are identified and inventoried • Mechanism defined for responding to a spill/breach of containment • Chemical and regulated medical waste addressed • Hazardous gas and vapors addressed • Orientation and education of staff outlined

Policy Required	Recommended Risk Management Elements
Infection Control	<ul style="list-style-type: none"> • Basic overview of infection control and how it relates to controlling disease • Hand washing outlined, when and how • Universal precautions addressed, including glove use • Personal protection equipment addressed • Screening employees for TB • Vaccinating employees for Hepatitis B • Steps taken when employee is exposed to breach of infection control or exposure, how to report to OSHA
Medical Emergency	<ul style="list-style-type: none"> • Mechanism in place for responding • Medical emergency code is identified • Identify who directs activities • Identify who determines if 911 is called
Medication Management	<ul style="list-style-type: none"> • Mechanism in place for procuring, storing, controlling and distributing medications • Narcotics addressed, even if to say they are not kept at the location of practice • Recalls addressed • Emergency and sample drugs addressed • Sign-out log covered • Prescription pad accessibility addressed
Non-Medical Emergency Policy	<ul style="list-style-type: none"> • Mechanism in place for responding • Include power outages, weather emergencies, bomb threats, and both fire and fire drills
Treating Unaccompanied Minors Policy	<ul style="list-style-type: none"> • Minor defined, exceptions covered • Scheduling appointments addressed • Mechanism in place to respond when an unaccompanied minor calls/arrives asking to be seen • Sample of authorization to consent to treatment of a minor is provided

Continuity and Coordination of Care

Rationale:

Member continuity and coordination of care (COC) across settings such as inpatient and ambulatory care and transition from specialty to primary care, is critical in ensuring the best care for Blue Cross' Members. All Practitioners/Providers share a joint responsibility to ensure continuity and coordination of care.

Requirements for Health Records:

- Establish a consistent location(s) for external communications from facilities and/or consultants including but not limited to discharge summaries or notes, consult letters, progress notes, and test or lab results.
- Communication is maintained in a chronological order.

Requirements for Referrals:

- Communicate with specialists/consultants the rationale for the referral (is the patient being referred for a consultation or ongoing care) and set expectations for future communications.
- Information, radiology, lab/test results, etc. are made available to the specialist/consultant in time for the patient's visit.

Requirements for Specialty Care and Consultants:

- Provide written communication to the patients' primary care provider including, but not limited to progress notes, consultation letters, and test or lab results.

Requirements for Inpatient:

- The attending physician copies all discharge summaries and discharge notes to the primary care provider.

Requirements for Emergency and Urgent Care:

- Correspondence regarding all emergency room and urgent care visits are copied to the primary care provider.

Patient Safety

Blue Cross is committed to establishing high standards of care for its Members. To assure these high standards, Blue Cross expects all participating Practitioner/Providers to be familiar with and actively involved in patient safety practices. Blue Cross supports the work of the Leapfrog Group, a national coalition of major employer groups, which has established patient safety standards. Blue Cross also supports national health improvement initiatives, such as the Institute for Healthcare Improvement's Triple Aim – applying integrated approaches to simultaneously improve care, improve population health and reduce costs per capita.

Blue Cross also works to ensure patient safety by monitoring and addressing quality-of-care issues identified through pharmacy utilization data, continuity and coordination of care standards, disease management program follow-up, and Member complaints.

Resources

Resources are available to Provider for information and to assist in the continuation of safe practices.

The following websites have patient safety programs and materials that Provider may find useful:

- Agency for Healthcare Research and Quality (Dept of HHS)
 - <https://www.ahrq.gov/>
- Institute for Healthcare Improvement
 - www.ihl.org

**Patient Safety
(continued)**

- The Joint Commission International Center for Patient Safety
 - www.jcipatientsafety.org
- Leapfrog Group for Patient Safety
 - www.leapfroggroup.org
- Minnesota Alliance for Patient Safety
 - www.maps.org
- National Quality Forum
 - www.qualityforum.org

Provider Site Visits

Blue Cross requires Providers to participate in on-site evaluations if:

- The Provider is unaccredited by a Blue Cross approved accrediting agency.
- Triggered by a Member complaint that can only be resolved by an on-site visit.

The site visit may include evaluation of medical record keeping practices, physical environment & access, QI improvement activities, and medical policies. For more detailed information for when site visits are required and on what is specifically reviewed, please refer to the Blue Cross Blue Shield Blue Plus of Minnesota (Blue Cross) Credentialing and Recredentialing Provider Policy Manual.

Medical Record Keeping Practices

Rationale:

Blue Cross requires its Practitioners/Providers to have a policy and procedure for confidentiality of health information and medical records that meet state and federal requirements.

Blue Cross expects strict adherence to state and federal laws with regards to maintaining Members' medical information and records in a confidential manner. Blue Cross requires medical records to be maintained in a manner that is current, detailed and organized. Practitioner/Providers must have a tracking process in place for ease of retrieval.

Requirements:

All Practitioners/Providers will have a policy and procedure in place to address the following:

- A written policy and procedure of medical record keeping practices, which includes the confidentiality and security of medical records, and release of information, is available.
- Medical records are kept in a secure or electronically secure location.
- Review of the confidentiality policy and procedure is performed at least annually with staff.
- A tracking system for medical records is in place.
- The medical record forms are available for release.

Medical Record Documentation**Rationale:**

The patient medical record is a vehicle for documenting services provided and evaluating continuity and coordination of care. It also serves as legal protection for the patient and practitioner. Blue Cross, per contractual agreement with both the Member and Provider, has access to the Member's medical record for examination and evaluation. Blue Cross' corporate confidentiality policy requires that the personal and health information of its Members be maintained as confidential information. All employees are required to attest to their knowledge of this policy and their intent to comply with it.

Medical record review is an essential component of a comprehensive Quality Improvement program. The Blue Cross Quality Council, which includes practicing physicians, establishes minimum patient medical record documentation standards.

Requirements:

All Practitioner/Providers will have a policy and procedure in place to address the following:

Format

- The content and format of the medical record is organized and includes patient's address and home and work telephone numbers.
- Each page in the medical record contains the patient's name or identification number.
- All entries in the medical records contain the author's identification. Author identification may be a handwritten signature, a unique electronic identifier, or a stamped signature verified with initials.
- Medical records are legible to someone unfamiliar with the author's handwriting.
- All encounters/entries are dated.
- Immunization status information for all ages is recorded on a single page location.
- A summary of preventive services screening is documented in a consistent place.

Medical Record Documentation (continued)

Content

- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Significant illnesses and medical conditions are indicated on a problem list.
- Past medical history (for patients seen three or more times) is easily identified and includes, as appropriate, significant family history, serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
- For patients 10 years and older, there is an appropriate notation concerning the use of tobacco, alcohol and substances.
- The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints and includes medications.
- A notation as to the presence of an advance directive is prominently noted in the record.

Assessment and Plan

- Laboratory and other studies are ordered, as appropriate
- Assessment of each encounter reflects patient's chief complaint
- Treatment plans are consistent with diagnoses

Follow-up

- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- If a consultation is requested, there is a note concerning this visit in the record.
- Consultation, lab and imaging reports filed in the chart are reviewed by the primary care physician.
- Clinically significant abnormal consultation results, lab or imaging study results have an explicit notation in the follow-up plans.

Clinical Practice Guidelines

Blue Cross believes that the use of clinical practice guidelines is a key component of Quality Improvement. At least once every two years, Blue Cross's Quality Management Committee approves the adoption of select guidelines that are used to support various programs and initiatives. The guidelines do not substitute for sound clinical judgment; however, they are intended to assist clinicians in understanding key processes for improvement efforts.

Note about Coverage:

This information is not an offer of coverage, solicitation of coverage, summary of coverage or guarantee of coverage. All products and coverage guidelines are subject to applicable laws and regulations. Member or provider coverage is contingent on all the applicable terms, conditions, limitations and exclusions of the member's benefit book or provider's agreement.

Many Blue Cross products cover some preventive care services without cost-sharing to align with Affordable Care Act recommendations.

Recommended Sources

Blue Cross recognizes the following sources for Clinical Practice Guidelines for the selected conditions and services below:

Condition	Specific Guidelines	Population	Source / Guideline Link
Behavioral Health			
Attention-Deficit / Hyperactivity Disorder (ADHD)	Clinical Practice Guideline for the Diagnosis, evaluation, and treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (2019)	<ul style="list-style-type: none"> Children and Adolescents (ages 4-18) 	AAP
Depression	APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (2019)	<ul style="list-style-type: none"> Adolescents General Adults Older Adults (ages 60 and over) 	APA
Opioid Use Disorder	The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (2020)	<ul style="list-style-type: none"> Adolescents (ages 11-21) Adults 	ASAM

Recommended Sources

Blue Cross recognizes the following sources for Clinical Practice Guidelines for the selected conditions and services below:

Condition	Specific Guidelines	Population	Source / Guideline Link
Acute or Chronic Conditions			
Asthma	Guidelines for the Diagnosis and management of Asthma (2012 with focused updates in 2020)	All ages	NHLBI
Chronic Obstructive Pulmonary Disease (COPD)	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2024)	All ages	GOLD
Diabetes	Standards of Care in Diabetes (2024)	All ages	ADA
Heart Failure	2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines (2022)	Adults	ACC
Hypertension	2017 ACC/AHA/AAPA/ABC/ACPM / AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2017)	Adults	ACC/AHA
Osteoporosis	BHOF's Clinician's Guide to Prevention and Treatment of Osteoporosis (2022)	<ul style="list-style-type: none"> • Postmenopausal Women • Men (ages 50 and older) 	BHOF

Recommended Sources

Blue Cross recognizes the following sources for Clinical Practice Guidelines for the selected conditions and services below:

Condition	Specific Guidelines	Population	Source / Guideline Link
Preventive Care Guidelines			
Preventive Services	Preventive Services for Adults	Adults	USPSTF
	Preventive Services Children and Adolescents	<ul style="list-style-type: none"> Children and adolescents 	USPSTF
	Routine Prenatal Care	<ul style="list-style-type: none"> All pregnant persons 	USPSTF

Additional Sources

Blue Cross recognizes the following sources for Clinical Practice Guidelines for a variety of areas of clinical practice:

- AACAP: American Academy of Child & Adolescent Psychiatry
[Practice Parameters and Resource Centers \(aacap.org\)](#)
- AAFP: American Academy of Family Physicians
[Clinical Practice Guidelines | AAFP](#)
- AAP: American Academy of Pediatrics
[Patient Care \(aap.org\)](#)
- ACIP: Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDC)
[ACIP Vaccine Recommendations | CDC](#)
- ACC: American College of Cardiology
[Guidelines & Clinical Documents - American College of Cardiology \(acc.org\)](#)
- ACP: American College of Physicians
[Clinical Practice Guidelines and Recommendations | ACP \(acponline.org\)](#)
- ADA: American Diabetes Association
[American Diabetes Association \(diabetesjournals.org\)](#)

**Additional Sources
(continued)**

- AGS: American Geriatrics Society
[Guidelines & Recommendations | American Geriatrics Society](#)
- AHA: American Heart Association
[Guidelines and Statements - Professional Heart Daily | American Heart Association](#)
- APA: American Psychiatric Association
[American Psychiatric Association Practice Guidelines \(psychiatryonline.org\)](#)
- ASAM: American Society of Addiction Medicine
[ASAM Clinical Guidelines](#)
- BHOFF: Bone Health & Osteoporosis Foundation
[Clinical Guidelines — Bone Source](#)
- HRSA: Health Resources and Services Administration
[Health Resources and Services Administration | HRSA](#)
- NCCN: National Comprehensive Cancer Network
[Treatment by Cancer Type \(nccn.org\)](#)
- NHLBI: National Heart, Lung and Blood Institute
[NHLBI Publications and Resources | NHLBI, NIH](#)
- USPSTF: U.S. Preventive Services Task Force
[Recommendation Topics | United States Preventive Services Taskforce \(uspreventiveservicestaskforce.org\)](#)

Quality Improvement for Behavioral Health Practitioner/Providers

General Overview

This section contains detailed information about the Blue Cross Quality Improvement (QI) program that is specific to Behavioral Health Practitioner/Providers. The information in this section is in addition to or more specific than the requirements in the greater chapter. The material explains what is expected from participating Practitioner/Providers regarding their **quality** programs and defines Practitioner/Provider requirements.

Cooperation with Blue Cross QI Program

Rationale:

Collaborative efforts need to mutually serve Blue Cross' Members and Practitioner/Provider's patients with excellent care and services.

Requirements:

Actively participate in the following Blue Cross QI activities.

Standardized substance abuse screening in mental health assessment.

- Routinely incorporate a substance abuse screening questionnaire, e.g., CAGEAID, AUDIT, during mental health assessment of new patients age 12 and under.
- Recommend or complete diagnostic assessment for a substance use disorder based on positive screening results and corroborating clinical information.

Exchange of information with primary care physicians

- Routinely ask new patients to authorize communication with their physician and document authorization or refusal.
- When authorized, document communication with the physician, e.g., report, letter, telephone or email.
- Authorized communication should include diagnosis, general treatment plan, and if treated by a psychiatric practitioner, initial medication management information.

Standardized treatment response monitoring for depression

- Routinely administer the Patient Health Questionnaire-9 for adults with Major Depressive or Dysthymic Disorder to monitor treatment response.

Access and Availability Rationale:

Members' concept of the quality of care they receive often begins when they make an appointment. Blue Cross wants to ensure that Members are able to schedule appointments in a timely manner; commensurate with the level of care they need.

Requirements:

Routine initial appointments: 90% of requests within 10 business days. Routine care is defined as a circumstance in which the individual does not present either emergent or urgent conditions and requests clinical services.

Follow-up appointment: 90% of requests within 10 business days of the initial appointment.

Urgent appointment: 100% of requests within 24 hours. Urgent care is defined as a circumstance in which the individual presents no emergency or immediate danger to self or others; however, the individual, clinician, or concerned party believes that the individual's level of distress and/or functioning warrants assessment as soon as possible. An urgent condition is a situation that has the potential to become an emergency in the absence of prompt treatment.

Non-life-threatening emergency appointment: 100% of requests within 6 hours or refers the Member to the emergency room. A non-life-threatening emergency is defined as a circumstance in which the individual is experiencing a severe disturbance in mood, behavior, thought, or judgment. There may be evidence of uncontrolled behavior and/or deterioration in ability to function independently that could potentially require intense observation, restraint, or isolation.

Emergency care: 100% of Member requests immediately. An emergency is defined as a circumstance in which there is imminent risk of danger to the physical integrity of the individual; the individual cannot be maintained safely in his or her typical daily environment.

Member Satisfaction (surveys) -

- **Routine Care:** 87% of Members will usually or always be satisfied with when they get a routine care appointment (routine care is when the Member does not need to see a practitioner right away).
- **Urgent Care:** 67% of Members will usually or always be satisfied with when they get an urgent care appointment (urgent care is when the Member needs to see a practitioner right away, for an illness, injury or condition).

Physical Location of Practice

Rationale:

Blue Cross requires Behavioral Health Providers to provide a safe environment, which protects patient privacy and ensures handicap accessibility for disabled patients. Blue Cross will monitor and review physical environment to evaluate conformity with regulatory, plan, and accreditation standards.

Requirements:

- Practitioner/Provider is open reasonable working hours
- Practitioner/Provide 24 hour/7 day on-call coverage
- Accessibility for handicapped Members as defined by the *Americans with Disabilities Act, 1990*
- Controlled substances are secure in a locked cabinet or space and dispensation is logged
- A system is in place to ensure that all medications are within the expiration date

Written Policies

Rationale:

To protect the safety and privacy of all Members, and for the protection of the Practitioner/Provider, Blue Cross requires all Behavioral Health Providers to develop and implement written policies and procedures. Practitioner/Providers are encouraged to have policies that are specific to the location of practice and are signed, dated and reviewed annually.

Requirement:

Each location of practice will have policies and procedures in place for the following topics in addition to policies listed previously in this chapter.

Policy Required	Recommended Risk Management Elements
Behavioral Health Accessibility Standards	<ul style="list-style-type: none"> • Access to Behavioral Health appointments commensurate with clinical need • Access to follow-up appointments commensurate with clinical need • Crisis access to clinician 24 hours a day/7 days a week

Treatment Record Documentation**Rationale:**

The patient Behavioral Health treatment record is a vehicle for documenting services and evaluating continuity and coordination of care. It also serves as legal protection for the patient and practitioner. Blue Cross, per contractual agreement with both the Member and Provider, has access to the Member's record for examination and evaluation. Blue Cross' corporate confidentiality policy requires that the personal and health information of its Members be maintained as confidential information. All employees are required to attest to their knowledge of this policy and their intent to comply with it.

Treatment record review is an essential component of a comprehensive Quality Improvement program. The Blue Cross Quality Management Committee establishes minimum record documentation standards.

Annually, Blue Cross audits a random sample of patient records from the Blue Cross population. The records are reviewed in accordance with the required documentation elements. If potential deficiencies are identified at a given site, a more intensive review may occur.

Requirements for Treatment Record Format and Content**Record Organization**

- The format of the treatment record must be logical and organized.
- All forms used in the treatment process must be standardized and consistent for all records.
- The treatment record must contain the patient's current address, employer or school, home and work phone numbers, marital or legal status, appropriate consent forms, and guardianship status information.
- **Special status situations, such as imminent risk of harm, suicidal or homicidal ideation, or elopement potential, must be prominently documented and updated.**
- There must be a signed patient authorization for all external persons with whom treatment information is exchanged. No treatment information can be exchanged without patient authorization or court order.
- Each page in the record must contain the patient's name or identifying number.
- All entries must be legible to someone unfamiliar with the author's handwriting.

Treatment Record Documentation, continued

- All entries must be dated and contain the author's name, professional degree/designation, and relevant identification number if applicable. If a non-degreed professional completes the entry, the title of the author must accompany the signature, e.g., Family Skills Worker. Author identification may be a handwritten signature or unique electronic identifier. Initials alone are not an acceptable form of identification. Initials may be used in conjunction with a typed signature block that clearly identifies the author.
- Errors in documentation must be corrected with a single line drawn through the error with the author's initials.

Initial Assessment

- Presenting problem(s), as well as relevant psychological or social conditions affecting the patient's medical or psychiatric status, must be documented.
- Presenting symptoms that are consistent with DSM-5 criteria must be clearly identified and documented, including the onset, duration, and intensity of symptoms as well as functional impairment.
- A psychiatric history must be documented. The psychiatric history should include, if applicable, previous treatment dates, identification of former treating practitioner(s), therapeutic interventions and responses, relevant family psychiatric history, lab test results, and consultation reports.
- A medical history must be documented which includes current and/or past major or chronic medical conditions and a current list of medications. Medication allergies and adverse reactions must be prominently noted. If the patient has no known allergies or history of adverse reactions, this must be noted.
- For children and adolescents through age 17, a comprehensive developmental history must be documented that includes prenatal and perinatal events, achievement of developmental milestones, and psychological, social, intellectual, and academic history must be documented.
- For individuals 10 years and older, a substance use history must be documented. The history must include past and present use of tobacco, alcohol, illicit drugs and any misuse of prescription or over-the-counter drugs. Additionally, negative consequences of use and history of assessment and/or treatment should be documented.
- Standardized substance abuse screening questionnaire results should be incorporated into the assessment of all new patients 12 years and older.

Treatment Record Documentation, continued

- A social history that includes family history, current family status, history of physical, sexual or mental abuse or trauma, current social network, and academic or vocational status must be documented.
- A mental status examination which includes, at minimum, information about appearance, speech, affect, mood, thought content, judgment, insight, attention, concentration, memory, and impulse control must be documented.
- **A risk assessment that identifies level of risk for harm, including suicidal, homicidal or elopement risk, must be predominantly documented.**
- Patient strengths and weaknesses that enable or inhibit the individual's ability to achieve treatment goals must be documented.
- An initial treatment plan must be documented.
- All Behavioral Health Practitioners must attempt consultation and coordination of treatment with the patient's primary care or treating physician. Patient authorization must be obtained prior to the release of any information. If the patient does not wish to have treatment information exchanged, patient refusal must be documented.

Diagnosis

- A DSM-5 diagnosis must be documented. The diagnosis must be consistent with presenting problems, symptoms, clinical history, mental status exam, and other clinical data.
- All five axes must be documented according to the DSM-5 multi-axial diagnostic system. The fifth digit of Axes I and II diagnoses must be listed when applicable.
- ICD-9-CM or ICD-10-CM codes must be used when submitting claims for payment.

Treatment Plan

- The treatment plan must be comprehensive, current, and consistent with the diagnosis. The formal treatment plan must be completed within the first three visits.
- The treatment plan must contain clear, objective, and measurable goals as well as the estimated timeframes for goal attainment or problem resolution. Interventions must be appropriate for the diagnosis and/or presenting problem(s).
- The patient must participate in the development of the treatment plan and should sign the initial plan and sign or initial all updates or revisions.

Treatment Record Documentation, continued

Progress Notes

- All entries must contain the date, actual face-to-face contact time, and current diagnosis.
- All entries must document the persons present during the visit without using the names of persons other than the identified patient.
- The interventions must be consistent with the diagnosis and correspond with current treatment goals.
- Recommendations or referrals for preventive or other external services, e.g., stress management, relapse prevention, or community services, must be documented.
- The documentation of each entry must clearly state the chief complaint and current status of symptoms as well as patient strengths and limitations in reaching treatment goals.
- There must be a notation in each entry about need for follow-up care, plans for a return visit, or termination of treatment. The specific date or timeframe of a return visit must be noted.
- There must be documentation of patient cancellation or failure to show for a visit.
- Evidence of coordination of care with other relevant Behavioral Health Providers and/or medical professionals must be documented.
- Unresolved problems from previous visits must be addressed and the outcomes documented.
- **If safety or risk characteristics are identified, they must be prominently documented and addressed during each visit.**
- Phone conversations with persons relevant to treatment, e.g., referral sources, physicians, or parents, must be documented.

Medication Management

- Significant illnesses, clinical risks, and medical conditions are to be clearly noted and revised periodically.
- Current medications prescribed by all prescribing physicians must be listed. Dosages and dates of initial prescription and/or refills must be documented.
- Evidence of informed patient consent for the receipt of medication must be documented.

Laboratory orders and results must be documented as well as review of the results by the ordering physician. If abnormalities are found, follow-up plans must be documented.

Provider Specific Health Care Data

Release of Provider Data

Blue Cross is permitted to release Provider-specific health care data for the purpose of allowing Members, Plan Sponsors, Providers, and others to compare the cost and/or quality of care offered by the Provider. Provider-specific health care data may include, but shall not be limited to, demographic information, utilization information, quality of care measures and initiatives, Health Service volumes, efficiency analysis, credentialing information, outcome measures, Member satisfaction results, costs and similar data.

Provider agrees to provide or assist in the provision of such Provider-specific data. Upon written request of the Provider, Blue Cross shall make a good faith effort to make available to the Provider a description of how Blue Cross intends to use Provider-specific data, the methodology used in collecting and analyzing the data and, a copy of the Provider data that Blue Cross intends to disclose. To the extent Provider can reasonably demonstrate, in writing, that any data that Blue Cross intends to disclose is inherently inaccurate, Provider shall notify Blue Cross of its specific concerns.

Blue Cross shall make a good faith effort to resolve Provider's concerns, provided however that Blue Cross shall have the sole and final discretion, responsibility and authority over the content, dissemination and release of such data.

Chapter 4

Care Management

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Care Management

Introduction

The Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Provider Service Agreement requires Providers to comply with Care Management programs administered by Blue Cross. These Care Management programs are designed to ensure that the Health Services subscribers receive care that is reimbursable according to the Medically Necessary and Appropriate guidelines in subscriber Contracts. In addition, Blue Cross reviews experimental/investigative and new procedures/services for coverage determinations. Care Management programs also ensure the most cost-effective and appropriate use of the health care delivery system.

These programs may include:

- Prior Authorization or Notification of selected procedures, services, supplies, and drugs
- Admission Notification, Prior Authorization and concurrent reviews for selected inpatient admissions
- Retrospective review of claims and medical records
- Case Management, Condition/Disease Management and Maternity Management

To make utilization decisions, Blue Cross uses established utilization review decision criteria based on sound clinical evidence. The criteria used to evaluate an individual case are available, free of charge, upon request for Providers' review.

Any medical drug requests/claims reviewed will be assessed according to FDA approved drug labeling and indication, and/or CMS-recognized compendia for accepted off-label uses. If it is determined that a drug request/claim does not meet applicable criteria, the request/claim may be denied. Coverage may also be subject to pharmacy benefit management programs and formulary restrictions.

Objectives

Care Management programs are designed to:

- Maximize the coordination of care and health outcomes
- Ensure appropriate and efficient utilization of health care resources
- Promote efficient use of health care resources
- Define and agree upon appropriate standards of care
- Manage service for subscribers with complex care coordination needs
- Identify gaps in subscribers' care and navigation of resources
- Identification of subscribers with conditions that will benefit from self-care efforts, care intervention and communication

Provider Contractual Obligations – Important Program Points

The following points pertain to all of the Care Management programs. Any Medical Necessity denial determination may be discussed with a physician reviewer by telephone.

- Any Health Services denied using Blue Cross' Medical Necessity guidelines cannot be billed to the subscriber unless the Provider has specifically notified the subscriber **prior to the Health Services being rendered** that the Health Service is not Medically Necessary and will not be covered, and the subscriber has agreed in writing to pay for the Health Service. This applies to investigative services as well as some non-covered services for mental health. (Refer to Waiver Section.)
- The Care Management process is a review for Medical Necessity only. Payment for Health Services is still subject to all other terms of the subscriber Contract. Therefore, denials may occur for preexisting conditions, benefit maximums, coordination of benefits or riders in the subscriber Contract that supersede Medical Necessity.
- Blue Cross makes available provider portal self-service, Availity and the provider services center to verify subscriber coverage, benefits, eligibility and limitations. Service representatives will also verify which Care Management procedures apply to the subscriber Contract.
- Providers will be held financially liable for Health Services rendered that are determined to be not Medically Necessary during a review or an audit process, even if prior authorization and/or concurrent review is not recommended.

**Care Management
Decision Making**

Care Management including utilization management (UM) decision-making is based only on appropriateness of care, service and existence of coverage. Blue Cross does not compensate Providers, Health Care Practitioners or other individuals conducting utilization review decision-making activities for denials of coverage or service. Blue Cross does not offer incentives to decision-makers to encourage denials of coverage or service that would result in less than appropriate care or underutilization of appropriate care and services.

Blue Cross UM decision-making processes ensure that subscribers are not discriminated against in the delivery of Health Services consistent with the benefits covered in their subscriber Contract based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment through the use of specific clinical criteria and consideration of the individual needs of each case.

This statement exists to inform and remind Providers, their employees, their supervisors, upper management, medical directors, UM directors or managers, licensed UM staff, and other personnel and UM staff employed by Providers who make utilization management decisions of this philosophy and practice. This includes delegates conducting utilization management services on behalf of Blue Cross.

Utilization Management

Purpose

The purpose of the Utilization Management (UM) Program is to promote effective, appropriate and efficient use of medical and behavioral health care resources for our subscribers.

According to Minnesota statute, “Utilization review’ means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending health care professional, for the purpose of determining the medical necessity of the service or admission.”

The UM program is a set of continuously improving processes, designed to both meet subscribers' needs, as well as regulatory and accreditation requirements. The UM program includes processes for:

- Monitoring and analyzing utilization trends
- Identifying members with complex health issues that may benefit from case or disease management
- Ensuring UM procedures provide effectiveness and compliance with federal and state laws and accreditation requirements.

Care Management uses the UM program processes, procedures and criteria to review and coordinate subscribers' benefits to enhance the efficiency, affordability and quality of care.

Goals

The UM program purpose of promoting effective, appropriate, and efficient use of health care resources is accomplished by adhering to the UM processes described in this program. The program goals are to:

- Ensure objective and consistent utilization management decision-making
- Ensure that subscribers have access to appropriate and timely medical and behavioral health care across the provider network
- Improve service and claims processes to provide optimal handling of prior authorization and post-service payment
- Ensure timely resolution of identified problems
- Continually build and maintain collaborative relationships with medical and behavioral health care providers

**Care Management
Medical and Behavioral
Health Clinical Staff**

Care Management medical and behavioral health clinical staff are responsible for the coordination of utilization management functions for eligible subscribers. Clinical staff are required to maintain an active unrestricted health license in Minnesota. The Care Management medical and behavioral health clinical staff are permitted to approve requested authorizations based on plan documents, policies, procedures, and established medical and behavioral health clinical criteria. Physicians or appropriately licensed peer reviewers make necessary medical necessity denials.

Contractual benefits, Medical Necessity, appropriateness, and individual needs are evaluated during the review process to determine coverage of Health Services. All requests for services that do not meet Medically Necessary and Appropriate criteria are reviewed through the physician peer review process.

UM decision-making is based only on appropriateness of care and service, and existence of coverage. No financial incentive is awarded to clinical staff for denying requests for service or based on coverage decisions.

Medical Policy

Medical and Behavioral Health Policy Development

Blue Cross applies medical policies in order to determine benefits consistently for its members. Internally developed policies are subject to approval by our Medical Policy Committee, which is made up of independent community Physicians who represent a variety of medical specialties. The remaining policies are approved by other external specialists. For all policies, the health plan's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches.

Blue Cross makes its determination of experimental, investigative or unproven based upon a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself:

1. Whether there is final approval from the appropriate government regulatory agency, if approval is required;
2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

The committee considers a number of additional factors when evaluating each of the criteria. These factors include, but are not limited to, quality of the available peer-reviewed medical literature; safety, effectiveness, appropriateness of technology; Blue Cross and Blue Shield Association requirements and Medical Policies; and the relevant impact and consequences of coverage for the technology (for example, patient, Blue Cross, ethical, societal, legal).

The following definition of "Experimental/Investigative," based on member contracts, applies:

The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by Blue Cross to be medically effective for the condition being treated. Blue Cross will consider an intervention to be Experimental/Investigative if:

- the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s),
- or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;

Medical and Behavioral Health Policy Development (continued)

- or the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies,
- or the intervention does not improve health outcomes,
- or the intervention is not proven to be applicable outside the research setting.

If an intervention, as defined above, is determined to be Experimental/Investigative at the time of the Service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, Prescription Drugs and other technologies. In turn, health care Plans must evaluate these technologies.

Blue Cross believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered Experimental/Investigative. Routine patient costs include items and Services that would be covered if the member was not enrolled in an approved clinical trial.

Medical Policy and Behavioral Health Policies

Medical and behavioral health policies are available for Providers' use and review at providers.bluecrossmn.com. From this site, there are two ways to access medical policy information depending on the subscriber's Blue Plan membership.

For Out-of-area Blue Plan subscribers

1. Select **Medical Policy and Pre-Certification/Authorization Router**
2. Click **Go**.
3. Select either medical policy or pre-certification/prior authorization.
4. Enter the subscriber's **three-character alpha/numeric prefix** (as found on their subscriber ID card)
5. Click **Go**.

After the disclaimer, the next page will show the subscriber's home Plan and provide information on Pre-certification/pre-authorization.

Medical Policy and Behavioral Health Policies (continued)

For local (Minnesota) Blue Cross Plan subscribers

1. Under the **Tools and Resources**, select **“Medical Policy”**
2. **Read and accept** the Blue Cross Medical Policy Statement
 - Select “+” next to ‘Medical and Behavioral Health Policies’ click on “Medical and Behavioral Health Policies” for access to all, currently, active medical policies.
 - The **“Upcoming Medical Policy Notifications”** section, on the website lists new, revised or inactivated policies approved by the Blue Cross Medical and Behavioral Health Policy Committee. They are effective, a minimum, 45 days from the date they were posted.

Prior Authorization & Notification Request Forms

Request forms are available at providers.bluecrossmn.com under *Forms & Publications* in the “forms-precertification/preauthorization/notification” section.

Prior Authorization/Notification

Overview

The purpose of Prior Authorization is to review Health Services prior to being rendered to determine if the Health Services are contractually eligible and Medically Necessary and Appropriate. Medical policy criteria and subscriber Contract language are used to assist in determining if benefits are available for the requested Health Service. **Prior Authorization for a Health Service, device or drug does not in itself guarantee coverage**, but notifies Provider that as described, the Health Service, device or drug meets the criteria for medical necessity and appropriateness. The Provider should always verify the subscriber's coverage is active and check the subscriber's contract benefits before requesting a Prior Authorization.

When requesting a required Prior Authorization:

- Submit the code that most accurately identifies the service(s) requested. Documentation in the patient's medical record must support the codes submitted.
- Do not use multiple codes when services can be represented by a single code, unless otherwise instructed.
- Unlisted codes should only be used if no code exists to describe the service or supply. Requests submitted with unlisted codes require a complete narrative description.

The Provider should submit documentation from the subscriber's medical record that supports the medical necessity of the requested Health Service, device or drug based on the applicable Medical Policy criteria. Blue Cross will evaluate Provider's request for Prior Authorization and will make a determination once all the necessary medical information is received. Blue Cross will contact the Provider if additional information is needed. The Provider must return all requested information to Blue Cross in a timeline manner in order for the request to be considered for approval.

Services that are determined to be Medically Necessary and Appropriate through the prior authorization process are only covered only if:

- The subscriber is enrolled in the health plan on the date of service
- The services or items are covered benefits
- The Provider is eligible for payment
- The Provider bills for the services that are approved

**Overview
(Continued)**

- There is no change in the subscriber's medical diagnosis or condition which results in the service or item requested being no longer medically necessary
- The subscriber continues to meet all applicable clinical criteria for the requested service or item

Blue Cross' approval of the requested service is not a guarantee of payment. Claim payments are conditioned upon the provider's submission of the most appropriate billing/procedure code(s) for the service(s) performed. Procedure codes submitted with prior authorization requests are not considered or assessed for coding appropriateness. **Claims for Health Services that are determined Medically Necessary and Appropriate must be coded in the most cost-effective manner when more than one coding option exists.** Submitting an incorrect or inappropriate code may result in a denial of the claim, and/or audit and recoupment.

Payment for services and/or supplies Blue Cross approves in advance are also subject to the terms of the subscriber's coverage including any applicable copays and/or deductibles, contract exclusions and health plan allowed amounts.

The Prior Authorization /Admission Notification lists found at bluecrossmn.com/providers/medical-policy-and-utilization-management identify various health services, procedures, prescription drugs, and medical devices that require Prior authorization or notification.

Note: Commercial, FEP, Medicare Advantage, Platinum Blue and Minnesota Health Care Programs have different Prior authorization lists and requirements.

Blue Cross also uses eviCore to manage several types of specialty programs:

- Fully-Insured and select Self-Insured Commercial members: Radiology/Cardiology, Musculoskeletal, Molecular Lab, Sleep, Medical Oncology and Radiation Therapy
- Medicare Advantage members: Radiology/Cardiology, Musculoskeletal, Molecular Lab, Sleep, Medical Oncology, Radiation Therapy, Post-Acute-Care, DME and Home Health.

**Overview
(continued)**

Reviews are completed by eviCore clinicians based on medical policies, processes and system applications that have been approved by Blue Cross.

The Blue Cross clinical reviewer uses local and national medical policy, Medicare guidelines, InterQual criteria, MHCP Guidelines, behavioral health criteria and subscriber Contract language to assist in determining if benefits are available for the request. Criteria are determined by the type of plan in which the subscriber is enrolled.

For behavioral health service requests, Blue Cross employs licensed behavioral health clinicians to conduct pre-certification/authorization reviews.

Scope and Purpose

These policies are applicable to all commercial and Minnesota Health Care Programs; medical, surgical, and behavioral health services are included.

Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies. Medicaid products may have additional policies and prior authorization requirements, as well as some self and fully insured plans. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law.

Admission Notification Requirements

An Admission Notification is a notice of service that does not require medical necessity criteria review to be completed at the time of admission. All covered services and admissions must be medically necessary and are subject to retrospective review or audit. Providers are responsible for charges if the Admission is found to be not Medically Necessary and Appropriate.

Admission Notifications are required to be submitted within 24 hours or on the next business day following a weekend or holiday, whichever is less, for both planned and urgent admissions. Admission notification is required for all inpatient admissions unless prior authorization is required for the admission. Continued stay notification is required for any admission that extends beyond the initially approved days. Providers are also required to notify Blue Cross when patients are discharged.

Admission Notification Requirements (continued)

For Minnesota Health Care Programs (Blue Advantage Families and Children, MNCare, MSC+) and SecureBlue claims beginning with admission dates of January 1, 2024, Blue Cross is partnering with vendor Audacious Inquiry, a wholly owned subsidiary of PointClickCare, to receive Admission, Discharge, Transfer (ADT) data for acute admissions.

Audacious Inquiry operates the MN Encounter Alert Service (MN EAS), an automated notification solution for the state of Minnesota with limited coverage in Wisconsin and North Dakota.

MN EAS enables providers throughout the state to transmit patient encounter alerts (ADT) for individuals who have been admitted to, or discharged or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real time. Blue Cross may outreach to providers on certain inpatient admissions to assist with discharge planning and member transitions.

For Minnesota MHCP subscribers, admission and discharge notification requirements will become automated for acute inpatient admissions at facilities located in Minnesota or a bordering county that are participating in the MN EAS service.

Providers will no longer need to submit admission, concurrent review, or discharge notification information in Availity Essentials.

- For providers that are not participating with MN EAS, admission and discharge notification are required and must be completed through Availity Essentials.
- For Subacute** facilities requiring prior authorization (PA), the provider must complete the PA and concurrent review processes (including medical record submission) through Availity Essentials.

Note: that MHCP eligibility information can be found in the MN-ITS system provided by the MN Department of Human Services (DHS).

Decision Making and Notification Time frames

To ensure timely processing and assist us in meeting compliance with state and federal guidelines, please submit prior authorization requests at least 10 business days prior to any elective services being rendered.

Urgent requests will be reviewed as expeditiously as the subscriber's health condition warrants and for all requests we will notify you of the coverage decision within the time frame required by law.

Definition of Urgent Request

The federal regulations define an urgent request as:

- Requires immediate action to prevent a serious deterioration of a subscriber's health that results from an unforeseen illness or an injury, or
- Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment, or
- In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

Care that has already been provided is not considered urgent.

Requests not meeting the conditions for an urgent request will be considered nonurgent. Both urgent and nonurgent requests will be reviewed and completed within current state and federal timelines.

For expedited requests, Blue Cross adheres to federal and state requirements for decision-making time frames. Blue Cross uses the following definitions to determine if a request is expedited:

For Commercial Plans

Requires immediate action to prevent a serious deterioration of a subscriber's health that results from an unforeseen illness or an injury, or

Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment, or

In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

Definition of Urgent Request (continued)

Requests not meeting the criteria for the urgent definition for an urgent request will be considered non-urgent. Providers submitting the request will be notified by Blue Cross that the request does not meet urgent criteria and will be managed according to non-urgent criteria. Both urgent and non-urgent requests will be reviewed.

For Medicare Programs

Although it may not be a life-threatening circumstance, an urgent condition:

- Requires immediate action to prevent a serious deterioration of a subscriber's health that results from an unforeseen illness or an injury; or,
- Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment; or,
- In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

If the need for service is for urgent care or services are required to prevent institutionalization, Blue Cross will evaluate the request for service and communicate the decision to the subscriber or authorized representative and the attending physician within an expedited timeline, not to exceed 24 hours.

Requests not meeting the criteria for the urgent definition for an urgent request will be considered non-urgent. Providers submitting the request will be notified by Blue Cross that the request does not meet urgent criteria and will be managed according to non-urgent criteria. Both urgent and non-urgent requests will be reviewed and completed within current state and federal timelines.

Utilization Management Services Requiring Prior Authorization/Notification

Overview

The Provider is expected to contact the Subscriber's Blue plan to request required prior authorizations.

The Provider is also responsible for completing admission notifications and/or prior authorizations for all inpatient admissions and may be liable for charges if notification to the home plan is not completed. When the length of an inpatient hospital stay extends past the previously approved days, any additional days must also be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

To avoid delays in the processing of Provider's claims, please assure the necessary approval(s) are obtained in advance of services being rendered.

There are two ways to access Prior Authorization/Notification requirements depending on the subscriber's Blue Plan membership (see below).

Prior Authorization Requirements for Out-of-area Blue Plan Patients

For Out-of-area Blue Plan subscribers

1. Select **Medical Policy and Pre-Certification/Authorization Router**
2. Click **Go**
3. Select pre-certification/pre-authorization
4. Enter the subscriber's **three-character alpha/numeric prefix** (as found on their subscriber ID card)
5. Click **Go**

After the disclaimer, the next page will show the subscriber's home plan and provide information on Pre-certification/pre-authorization.

Prior Authorization Requirements for Local Blue Cross Plan Patients

Commercial, Minnesota Health Care Programs, Platinum Blue and Medicare Advantage, and Federal Employee Programs (FEP) products have different Prior Authorization/Notification lists and requirements.

Prior Authorization Look Up Tool

Providers should use the Authorizations tool on the Availity Provider Portal to determine if an authorization is required for Commercial and Medicare products.

To access the Prior Authorization tool:

1. Log in at **Availity.com**
2. Select Patient Registration, choose Authorizations & Referrals, then Authorizations
3. Select Payer BCBSMN, your Organization, Transaction Type Outpatient and you will be redirected to the Authorizations Tool application

Prior Authorization/Notification requirements are also published at **blucrossmn.com/providers**:

1. Under the Tools and Resources, select “**Medical Policy**”
2. Read and accept the Blue Cross Medical Policy Statement
3. Select “+” sign next to “**Utilization Management**”.
4. Scroll to the link to the Prior Authorization/Notification list by line of business. These lists identify the services, procedures, prescription drugs, and medical devices that require precertification/authorization/notification.

Retro-Authorization

Certain circumstances may make obtaining a PA prior to rendering the service difficult. Retrospective clinical review will be considered by Blue Cross and eviCore for up to 14 days after the date of service and prior to the claim being submitted in consideration of scenarios such as after-hours urgent situations.

Exception: Retrospective authorization requests will not be accepted for chemotherapy reviewed by eviCore. Authorizations for genomic and molecular lab services reviewed by eviCore will be accepted for up to 60 days from the date of specimen collection.

Prior Authorization Denied, but Services Rendered

Services rendered without an approved prior authorization due to a determination of not medically necessary will be denied as not medically necessary. Related professional services and facility charges will also be denied as not medically necessary. Inpatient claims will be denied even if a precertification was received.

Required Prior Authorization Not Submitted

If a required prior authorization is not submitted the service will be denied. Related professional services and facility charges will also be denied. Inpatient claims will be denied even if a precertification was received. These denials cannot be appealed unless exceptions are met as outlined in Chapter 10: Appeals, 10-5.

Where to Send Requests

See *Chapter 1 – At Your Service* for the phone numbers, fax numbers or mailing addresses for Care Management.

Compliance Audit

Overview

The Provider Service Agreement includes certain quality assurance requirements. Pursuant to the Agreement, Blue Cross may conduct audits to evaluate Provider's compliance with Medical Necessity guidelines and standards of practice in the community. Such an audit could include post-service claims review, which may result in Provider liability if the care is determined to be not Medically Necessary or medically inappropriate.

Case & Condition/Disease Management

Overview

Mission Statement

The corporate mission of Blue Cross is to “Make a Healthy Difference in People’s Lives”.

Care Management staff supports this mission by working collaboratively with subscribers, providers, delegates, and the community to promote optimal health, and coordinate access to service across the continuum of care that is holistic, seamless and easily accessible. Blue Cross’ goal is to be responsive and respectful to those served by Blue Cross in order to decrease fragmentation of care, improve satisfaction and enhance quality of life. Blue Cross considers and supports the subscriber’s cultural and linguistic needs in order to achieve optimal health and overall subscriber satisfaction.

Clinicians

Licensed Nurses/Clinicians, using a collaborative process, advocate, assess, plan, implement, coordinate, monitor and evaluate options and services to meet an individual’s specific health care needs through education and communication of available resources to promote high quality, cost effective outcomes for subscribers with medical and behavioral conditions that require ongoing or intermittent care. Clinicians are required to maintain an active unrestricted health license in Minnesota.

Program Goals

- Maximize optimal health and functional outcomes.
- Identify gaps in care
- Reach out to the subscribers with the greatest need and educate them about their condition
- Support and encourage individual accountability for health and wellness (self-care management)
- Help subscribers coordinate their needs and navigate services in the health care system
- Tailor interventions and outreach to promote the appropriate use of health care services
- Improve subscriber’s satisfaction with the health plan and health care system

Referrals to Case, Maternity and Condition/Disease Management

Referrals to Commercial Case & Condition/Disease Management

A referral can be made by contacting the Nurse Guide Team at 1-866-489-6947

A referral for stop smoking can be made to Blue Cross Wellness Coaching at 1-888-662-2583.

Condition/Disease Management

Condition/Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations who have or are at risk for, chronic medical and behavioral health conditions. Condition/Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as education and self-management. The process of disease management evaluates clinical, social/humanistic and economic outcomes with the goal of improving overall health of the whole person.

Subscribers who receive Condition/Disease management services receive support from a case manager, who assists in facilitating the health of the whole person, not just their individual condition.

*Services are offered to subscribers, participation is optional.

*Subscriber eligibility for Condition/Disease management is determined by the subscriber Contract.

Condition/Disease States

Commercial & Medicare Advantage

- Chronic Kidney Disease (CKD)
- Heart Disease (CAD)
- Asthma
- Diabetes
- Chronic Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

Minnesota Health Care Programs

- Population Health
 - Depression
 - Diabetes (adult & child)
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Heart Failure
 - Heart Disease (CAD)
 - Asthma (adult & child)

Blue Cross provides behavioral health case and disease management for Blue Cross members using Blue Cross documentation systems, Blue Cross medical policies, and Blue Cross internal policies and procedures.

Maternity Management/Commercial

The Maternity Management program offers an expectant mother the tools and support needed throughout her pregnancy to help her make better informed decisions about her healthcare, in conjunction with her Provider. By enrolling in the Maternity Management program, the expectant mother will receive access to a case manager, who is a Registered Nurse (RN) with expertise in obstetrics and perinatal and comprehensive pregnancy and baby health education tools.

- A nurse or clinician may contact Provider's office for assistance with a Blue Cross subscriber's needs or to verify a subscriber's contact information. They may also send the Provider a letter including subscriber goals and/or gaps in care to inform Provider on what Blue Cross is working with the subscriber to advance their health care needs. Blue Cross looks forward to working with its subscribers' Health Care Practitioners to make a healthy difference in the health of its subscribers.

The Maternity Management program is available to all Blue Cross subscribers. Subscribers who trigger for high risk will be actively outreached to by the Maternity Management specialty team of nurse case managers. All other subscribers may contact Blue Cross to opt-in to the program.

Referrals to Maternity Management

To enroll, please instruct subscribers who are expecting a baby to see the back of their subscriber ID card for the appropriate contact number.

Minnesota Health Care Programs/Maternity Management

Experienced case managers work with members and providers to establish a care plan for the highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, breastfeeding support and counseling.

When it comes to pregnant members, Blue Plus is committed to keeping both moms and babies healthy.

All moms-to-be are encouraged to take part in the Maternity Management program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at high risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.

**Minnesota Health Care
Programs/Maternity
Management
(continued)**

Our case managers are here to help providers. If there is a member in your care that would benefit from case management, call Blue Plus at **1-800-711-9862**. Members can also call the 24/7 NurseLine at **1-888-275-3974**, 24 hours a day, 7 days a week.

NICU Program/Minnesota Health Care Programs

Blue Plus offers case management services to families of babies admitted to the NICU. Families receive education and support, care coordination, and resources to ensure the family and baby is prepared for discharge. Babies are identified through admission notification data sent to Blue Plus. This allows the Health Plan to proactively outreach to the families to offer support.

Restricted Recipient Program

The Restricted Recipient program is a specialized program for Minnesota Health Care Program subscribers.

- Blue Plus subscribers include subscribers with coverage through: Minnesota Health Care Programs for Persons Under Age 65 (Blue Advantage Families and Children and MinnesotaCare).

Restrictions of Medicare services are not allowable per DHS contract 2.130. For subscribers who are on Medicare integrated product (SecureBlueSM [HMO SNP]), it is permissible to restrict Medicaid-only services. Blue Plus is not able to restrict Part D drug coverage and implement physician sole prescribers for Minnesota Health Care Programs subscribers with Medicare (MSC+). If a MSC+ subscriber is not Medicare eligible, restriction is permissible.

Restricted recipients are subscribers who have used Health Services at a frequency or amount that is not Medically Necessary and/or who have obtained Health Services in an inappropriate manner.

Nurses in Care Management review subscribers' medical and pharmacy claims for potential restriction. Subscribers who meet the program criteria are assigned to a specific physician for their primary care needs who, in turn, will coordinate all their care and medication needs. The subscriber will also be assigned to a single pharmacy and a single hospital. Access to specialty care may be discussed with the nurse assigned to the subscriber. The initial program restriction is for 24 months with potential re-enrollment for 36 months.

Providers need to verify if a subscriber has a restriction before providing Health Services.

Restricted Recipient Program (continued)

Claims will be impacted if Provider renders Health Services to a subscriber enrolled in this program and Provider is not the assigned physician, pharmacy or hospital.

Eligible services provided to a subscriber in the program will be reimbursed only when one of the following criteria is met:

- The Health Service is provided by the subscriber's assigned provider
- The Health Service is of a provider type or type of service that is not listed as needing management
- The subscriber's assigned provider(s) submits a referral for services to be rendered at a different provider

This includes, but is not limited to, durable medical equipment (DME), home care, ambulance services, mental health or chemical health services. Nurses will refer suspect cases to the special investigation unit (SIU) as needed.

Focused Utilization Review

Overview

Focused utilization review programs contribute to Blue Cross' goals of containing health care costs by assuring that Health Services are contract benefits and appropriate. Blue Cross systematically monitors Health Services of providers for patterns of overuse, underuse, misuse and abuse in addition for obsolete or questionable practices.

Blue Cross has data warehousing and software programs that look for patterns outside established norms. The analysts review medical records and work with providers to resolve questions on coding, benefits and Medical Necessity and Appropriateness. On-site audits, using a sample of up to the last three years of claims history may be performed. Prompt response to medical records requests will speed up processing of claims under review. Claims are denied as Provider liability if the necessary information is not received.

During utilization review, claims are screened for Medical Necessity. Peer review agents or consultants deny claims only after careful evaluation. Slightly longer processing time is required for claims that must go through the utilization review process.

Participating Providers agree not to bill the subscriber for any services Blue Cross determines to be not Medically Necessary or investigative. Medical Necessity denials can be appealed within 30 days from the date Provider was notified. Blue Cross requests that Providers submit written appeals outlining the issues and ATTACH supporting documentation such as medical records, operative reports, and any medical information documenting unusual circumstances at the time of the request.

Special Investigations

Blue Cross actively investigates possible fraudulent claims submissions from both subscribers and Providers. Fraud and abuse investigations conducted by Blue Cross' special investigations department are among the most thorough in the industry. Inconsistent charges forged or altered charges, or Health Services billed but never rendered are just a few examples of inappropriate practices that Blue Cross may verify when conducting its investigation. Blue Cross' investigation process may include, but is not limited to, record requests, audits, and survey letters.

Blue Cross often conducts its investigations and criminal proceedings in collaboration with outside agencies such as the state attorney general's office, the FBI, postal inspectors, or local authorities. Blue Cross' goal is to protect Blue Cross subscribers and Providers from losses due to fraudulent acts.

Information about any person's inappropriate use of a Blue Cross policy, subscriber ID card, or questionable billing practices should be reported by calling Blue Cross' fraud hot line. The phone number is listed in *Chapter 1 — At Your Service*. Callers may remain anonymous if they wish.

Documentation in the Medical Record

Documentation Requirements

To avoid denials for Medical Necessity, the patient's medical record must contain certain pertinent information that may be subject to Blue Cross' review. The Centers for Medicare and Medicaid Services (CMS) in conjunction with the American Medical Association (AMA) has developed guidelines for the medical documentation necessary to support a given level of evaluation and management service. Blue Cross adopted these guidelines to ensure that its subscribers receive quality care and that the Health Services are consistent with the health plan coverage provided.

The general guidelines are listed below:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
 - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - Plan of care; and
 - Date and legible signature of the practitioner.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response and changes in treatment, and revision of diagnosis should be documented.
- The CPT/HCPCS and ICD-10-CM procedure codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Charge slips, super bills, travel cards, or office ledgers are not considered supporting documentation for services provided to a patient.

Use of the term IBID (same as above) and/or the use of quotation marks to replace or repeat previously documented information is not acceptable. All information must be in date-sequence order.

Health Services not documented as indicated above are not covered by Blue Cross. Subscribers are not financially liable for Health Services that are denied for inadequate documentation.

Overview

Per the Provider Service Agreement, Provider may not bill:

- Any subscriber for medically unnecessary or investigative services.
- Minnesota Health Care Programs, including Blue Advantage Families and Children- and MinnesotaCare subscribers for Health Services that are not covered at Provider's office, but may be covered if the subscriber went to another provider.

Provider may bill the subscriber only if the following conditions are met:

- The subscriber is notified prior to the Health Service being rendered that it is not a covered service, etc.
- The subscriber agrees, by signing a waiver, to pay for the service.

In addition, Provider should not direct subscribers to nonparticipating or non-network providers (Refer to *Referrals to Nonparticipating Providers*).

For Minnesota Health Care Programs: One of the DHS regulations includes subscriber rights to notification of non-covered Health Services. General signed statement information is included in the *Blue Cross Provider Policy and Procedure Manual, Chapter 6*.

The signed statement is allowed only when the Health Service provided is a non-covered service, and must be:

- Specific to the procedure/service (including the cost)
- Specific to a date of service
- Signed and dated by the subscriber for each date of service

If the signed statement is not signed by the Minnesota Health Care Programs subscriber prior to the Health Service, then according to DHS rules, the subscriber cannot be billed for the service. This includes Health Services that are investigative, not Medically Necessary, or excluded from coverage under the contract. Provider may bill a Subscriber for non-covered Health Services only when Minnesota Health Care Programs (MHCP) never covers the services and only if Provider informs the subscriber before Provider delivers the services that he/she would be responsible for payment. If MHCP normally covers a Health Service but the subscriber does not meet coverage criteria at the time of the service, Provider cannot charge the subscriber and cannot accept payment from the subscriber.

Overview (continued)

Blue Cross does not consider blanket (nonspecific) waivers sufficient notice to meet the subscriber notification requirements in the Provider Services Agreement. The waiver must be dated and must specifically identify the procedure or Health Service. The waiver must also advise the subscriber that he or she would not be liable for these charges unless the waiver is signed.

Organization Determination

An organization determination is required for Platinum Blue and Medicare Advantage members in order to have claims for non-covered Medicare services deny as Subscriber liability. The organization determination is required in order to provide the member an advance notification of the non-covered service, which would be their liability if they chose to continue with the service. An Advance Beneficiary Notice (ABN) is not valid for use with Platinum Blue and Medicare Advantage plans.

Non-Covered Medicare services without an Organization Determination

In accordance with Medicare requirements and the provisions of your agreement, it is the duty of the provider to assure that all services are Medicare eligible prior to rendering services.

Medicare National and Local Coverage Determinations (NCD & LCD) specify coverage criteria including specific documentation requirements which providers must follow.

If there are questions regarding whether a service or item will be covered or non-covered, providers may submit a request for an organization determination prior to rendering services. In addition, providers may submit an organization determination for any item when requested to do so by the member.

1. Medicare non-covered services that are called out in the Member's Evidence of Coverage (Benefit Book) under *What services are not covered by the plan* section do not require an organization determination.
2. If non-covered services are indicated in CMS documentation such as Medicare LCDs and NCDs, but are not called out in the member's Evidence of Coverage (Benefit Book) under *What services are not covered by the plan* section, an organization determination needs to be submitted. Without an organization determination on file, these services will be denied as provider responsibility. A waiver is not a valid replacement for the organization determination.

Organization Determination (continued)

3. If an organization determination is submitted to Blue Cross and denied as not covered, the claim will deny as patient liability if the following requirements are met:
 - The provider needs to inform the subscriber of the unfavorable organization determination prior to rendering the service.
 - A waiver is signed advising the member clearly what service(s) are not covered prior to the service(s) being rendered.

It is a contract requirement that a provider is responsible to submit claims to Blue Cross for all Health Services provided, even in cases when Provider suspects or knows a Health Service will not be covered. This will ensure the proper administration of benefits and take advantage of changes in coverage that may occur after Provider checks benefits. The GA modifier is not valid for Platinum Blue or Medicare Advantage policies.

Organization Determinations through Availity

The organization determination request needs to be submitted using the Authorization tool found on Availity.

1. The CMS codes with status indicator of “N” are not covered but will require an organization determination to be submitted. These services are not called out as “not covered” in the member’s Evidence of Coverage (Benefit Book) under *What services are not covered by the plan* section. These codes will have an automated response on Availity without review. Blue Cross is continuously reviewing codes and updating the member’s Evidence of Coverage (Benefit Book) to decrease the number of codes requiring an organization determination.
2. Codes that are sometimes covered will require an Organization Determination and will be reviewed for coverage.

**Organization
Determination
(continued)****Resources**

For details about items, tests or services covered by Medicare, see the comprehensive list at the Centers for Medicare & Medicaid Services website (link below). The organization determination is not required for Medicare covered services.

- Medicare.gov <https://www.medicare.gov/coverage/is-your-test-item-or-service-covered>
- CMS.gov <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Minnesota&Keyword=stem+cell&>

Blue Cross Prior Authorization and organization determinations should be submitted through Availity using the Authorization tool. The Authorization tool will not advise that an organization determination is required for Platinum Blue or Medicare advantage policies for Medicare non-covered services.

- The authorization tool will only send automated responses for Medicare non-covered codes with status indicator of “N”. If you enter multiple procedure codes and one of them requires review it may cause unnecessary delays. Please enter procedure codes that need review on a separate request to avoid delays. These codes are updated quarterly and subject to change.

Medical Referrals to Nonparticipating or Non Network Providers

Providers are required to direct subscribers to Blue Cross participating providers, hospitals and other facilities to the highest degree possible. Directories of participating providers are available at **bluecrossmn.com** or upon request by contacting provider services at **1-800-262-0820** or **(651) 662-5200**. Blue Cross maintains stringent provider participation standards and credentialing requirements and directing a subscriber to a participating provider improves the likelihood that a subscriber will receive high quality Health Services. In addition, subscribers will incur reduced benefits and higher patient responsibility when using nonparticipating or non-network providers.

Directing patients to nonparticipating providers may be necessary in limited situations such as medical emergency, participating providers are not available within certain geographic areas, or quality of care or specialty care requires use of a nonparticipating provider (access to care issue).

Note: For subscribers of Blue Plus who require managed care referrals, use the Referral Network directory available at **bluecrossmn.com**. Subscribers will receive the highest level of their benefits when receiving a referral to a participating provider for those specialty Health Services that require a referral.

If it is Medically Necessary to refer a Blue Plus subscriber to a nonparticipating provider, refer to Chapter 6 of this Provider Policy & Procedure Manual or contact the provider service center for further information at **1-800-262-0820** or **(651) 662-5200**. You may need to submit an out of network notification to the Health Plan. In all cases, Provider must give the subscriber advance, written notification that the referral is to a nonparticipating physician. Once notice is given, the subscriber is responsible for any increased liability if he or she decides to schedule the service except that Minnesota Health Care Programs subscribers cannot be held financially responsible for any increased liability regardless of the reason for the referral. If the subscriber is not properly informed, the provider making the referral to a nonparticipating provider will be liable for increased costs incurred by a subscriber.

For complete information on Minnesota Health Care Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

Sample Waivers

A sample waiver for use in Provider's office is available on Blue Cross' website. The waivers include the information required in order for Provider to hold the subscriber financially liable for services. The waiver should be incorporated into Provider's usual business forms and should be customized to include Provider's business letterhead.

**Upgraded/Deluxe
Durable Medical
Equipment (DME)****Commercial Business**

Participating durable medical equipment (DME) suppliers may bill subscribers for an equipment upgrade or deluxe charge if a waiver is on file and the DME charges are billed correctly to Blue Cross. Blue Cross continues to reimburse for Medically Necessary standard DME.

Minnesota Health Care Programs Business

For complete information on Minnesota Health Care Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

**DME Waiver
Requirement**

Participating DME suppliers must obtain a signed, written waiver from the subscriber that includes the cost for the deluxe features or upgrade. The waiver must also state the following:

- The standard piece of equipment or least costly alternative offered to the subscriber,
- The subscriber is aware and agrees that Blue Cross will only pay the standard allowance, and
- The subscriber will be responsible for the deluxe or upgrade charge in addition to his or her contractual obligation.

This waiver must be kept on file at Provider's office. If a prior authorization is required for the item being provided, please send the waiver form along with the request. For all services that do not require a Prior authorization, **do not send it to Blue Cross**. Blue Cross does, however, reserve the right to see it.

Sample DME Waiver

A sample waiver for use in Provider's office is available on Blue Cross' website. The waiver includes the information required in order to hold the subscriber financially liable for deluxe features or upgrades to a DME purchase. The waiver should be incorporated into Provider's usual business forms and customized to include Provider's business letterhead.

Chapter 5

Health Care Options

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Subscriber ID Cards/Health Coverage Options

Fully Insured Groups

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) fully insured contracts are available for employers that select our standard benefits. The employer can choose the deductible/coinsurance and copay amounts.

Fully insured contracts generally:

- offer consistent benefit options
- follow state mandates
- follow federal mandates
- have standard subscriber identification (ID) cards
- are regulated by the Department of Commerce (fee-for-service) or the Department of Health (managed care)

Self-Insured Groups

We also administer self-insured contracts in which the employer selects the benefits and assumes all or part of the financial risk. These may also be referred to as ASOs (Administrative Services Only). Self-insured contracts generally:

- offer many contract benefit options
- are not required to follow state mandates
- follow federal mandates
- have subscriber ID cards that may not be standard and may include the logo

Patients who belong to self-insured groups administered by Blue Cross are to be treated as any other subscriber for purposes of the provider contract. Because your office must bill us directly for these patients, it is important to check the back of the subscriber ID card to see if we are listed as the administrator of the health plan.

Subscriber ID Cards

Your patient's ID card contains information that is essential for claims processing. We recommend that you look at the ID card at every visit and have a current copy of the front and back of the card on file. There is a sample of some of the ID cards issued at Blue Cross on our website. Below are examples of the information you may find on an ID card:

- name of the plan
- patient's ID number including alpha prefix
- patient's name and group number
- primary care clinic (PCC) name – for managed care plans only
- prescription coverage
- copay for office visits, if applicable
- claims submission information

Subscriber ID Card Conversion

Blue Cross does not use Social Security numbers for ID cards; however, the Minnesota Department of Labor and Industry requires the use of social security numbers for anyone who has ever filed a worker's compensation claim.

Helpful Tips

- Ask patients for their current ID card and regularly obtain new photocopies (front and back) of the ID card. Having the current card will enable you to submit claims with the appropriate subscriber information (including alpha prefix) and group numbers to help avoid unnecessary claims payment delays.
- Check eligibility and benefits by using www.availity.com, BLUELINE or call **1-800-676-BLUE (2583)** and provide the alpha prefix.

Verify Identity of Cardholder

You should also verify the identity of Blue Cross cardholders by asking for additional picture identification.

If you suspect fraudulent use of a subscriber ID card, please call our fraud hot line at **(651) 662-8363**. You may remain anonymous.

Blue Cross and Blue Shield of Minnesota Coverage Options

Overview

Blue Cross offers a variety of health coverage options. A high-level summary of those benefit options available to employees follows in this chapter. All fully insured plans are compliant with Federal and State regulations. All benefits are subject to the terms of the subscriber's contract and/or certificate of coverage.

Please use provider web self-service, or provider services to identify your patient's eligibility and benefits.

Aware® PPO

Aware PPO is an open access product. Aware PPO is attractive to employers with employees in Minnesota and in other geographical areas.

BlueAccessSM

BlueAccess is a health plan for small employers. BlueAccess plans are open access and utilize the Aware® network. Some plans may include a health savings account (HSA) or health reimbursement arrangement (HRA). Plans include a range of cost-sharing options, including deductibles, copay and coinsurance.

High Value

High Value is a statewide plan for Large Group employers featuring high quality, low cost providers.

Metro MN

With a Metro MN plan, Large Group employers utilize a coordinated-care network. Metro MN provides a personalized, coordinated approach to health care with primary and specialty care providers through the Metro MN network.

Southeast MN

With a Southeast MN plan, Large Group employers utilize a coordinated-care network. Southeast MN provides a personalized, coordinated approach to health care with primary and specialty care providers through the Southeast MN network.

Medicare Supplemental Plans

Blue Cross offers a variety of Medicare supplement plans. Medicare supplement plans are designed to help fill the gaps in Medicare coverage.

In 2020, Blue Cross offers seven Medicare Supplement Plans: Basic Plan with optional riders, Senior Gold with optional riders, Extended Basic, Plan K, Plan L, Plan N and Medicare Supplement with High Deductible.

Under these plans, Medicare is the primary payer. Claims must be submitted to Blue Cross with a copy of the Medicare Remittance Advice (RA) form.

Platinum BlueSM (Cost) Platinum Blue, a Medicare-approved Cost plan, is an open access product for Medicare beneficiaries who are residents of Minnesota, offered through a contract with the Centers for Medicare and Medicaid Services (CMS).

No referrals are needed for in-network doctors, specialists or hospitals. Subscribers can receive plan benefits for services received outside of Minnesota, from any provider that accepts Medicare, when traveling for up to nine months per year (Travel Benefit). Travel benefit claims process as in-network, even though the subscribers are using out-of-network providers. Travel benefit claims process to Medicare first and crossover to Blue Cross as a secondary payer.

Travel benefits are not applied to out-of-network providers within the state of Minnesota. If, while in Minnesota, subscribers go to a provider outside of the Platinum Blue (Cost) network who accepts Medicare patients, subscribers are covered under Original Medicare and would pay the Part A and Part B deductibles and coinsurance.

Medicare Advantage MA and MAPD are Medicare Advantage Plans. They cover all Medicare Part A and B benefits (MAPD also covers Part D benefits). Services received outside of the network may not be covered or member costs may be higher. The plans do not require referrals and have out of pocket costs, including copayments and coinsurance.

HMO-POS (Strive) is a Health Maintenance Organization with a Point of Service Option. It is a Medicare Advantage Plan that has a network allowing members to seek care outside of the traditional HMO network under certain situations or for certain treatment. Services received outside of the network may not be covered or member costs may be higher. While typical HMO-POS plans require a PCC and a referral, Blue Cross is not enforcing those requirements. They cover all Medicare Part A, Part B and Part D benefits.

MedicareBlue Rx (PDP) This is a regional Medicare Part D Program product offered through the coordination of six Blue Cross plans covering seven states. The service area for this plan encompasses Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming.

This product offers two different benefit level options, both with a five tier formulary. Drugs in the formularies may be subject to change, step therapy, quantity limits or preauthorization.

PLEASE NOTE: Forms, formularies and provider information for MedicareBlue Rx can be found at:

[http://www.yourmedicareolutions.com /](http://www.yourmedicareolutions.com/)

This product is also available for fully insured employer groups to purchase for their Medicare eligible subscribers.

Blue Cross Dental

Blue Cross Dental plans are available to Individual/Family, Small Group, and Large Group. Plans can be purchased as a standalone dental plan or with a Blue Cross medical plan for administrative ease. These Blue branded products are available as part of a partnership with United Concordia Dental (UCD). As part of this relationship, UCD processes claims and will allow access to the Advantage Plus 2.0 (Individual/Family) and the Advantage Plus AXS (Commercial Group Markets) national dental networks.

Blue Cross Vision

Blue Cross Vision plans are available to Individual/Family members, Small Group, and Large Group. These Blue branded vision plans are available in partnership with Davis Vision. As a part of this relationship Davis Vision processes claims and allows access to the Davis Vision national network.

Guidelines for Determining Submissions to Medicare or Blue Cross

For services provided to Medicare subscribers enrolled in our Medicare supplement or Platinum Blue plan that are eligible under Medicare Part A, Medicare is primary. CMS will continue to be the primary payor for these services with electronic claims crossing over from Medicare intermediaries. Blue Cross will serve as secondary payor for these services with subscribers being subject to Medicare coinsurance and deductibles.

Blue Cross is the administrator for Medicare Part B non facility-based services and any additional Platinum Blue benefits. Reimbursement for professional providers utilize Blue Cross' contracted fee schedule methodology. To ensure CMS compliance, follow the guidelines outlined in standard Medicare bulletins and the Provider Policy and Procedure manual.

For Medicare subscribers enrolled in our Medicare Advantage plans, Blue Cross replaces Medicare as primary payor for Part A and Part B services.

**Inquiries and Claims
Platinum Blue (Cost)
and Medicare
Advantage**

Provider claim and benefit inquiries for Platinum Blue can be directed to provider web self-service, BLUELINE or provider services at **(651) 662-5200** or **1-800-262-0820**. Please have your provider ID and the subscriber ID ready when you call.

As a Medicare contracted provider, Medicare expects providers to know both current NCDs and LCDs. NCDs describe whether Medicare pays for specific medical items, services, treatment procedures or technologies.

The [Medicare Coverage Database \(MCD\)](#) contains all NCDs and LCDs, local policy articles and proposed NCD decisions. You may find published [NCDs](#), view official versions of [LCDs](#) by contractor, state, or alphabetically and information related to [Medicare coverage, regulations, and processes](#) visit the CMS website.

Blue Plus Coverage Options

Blue Plus Metro MN

Offered in the Individual & Family segment, the Blue Plus Metro MN product, has a coordinated-care network that provides a personalized, coordinated approach to health care with primary and specialty care providers. This product uses the Blue Plus Metro MN network.

High Value / Blue Plus Minnesota Value

High Value / Blue Plus Minnesota Value is a product offered in the Small Group and Individual & Family segments featuring high quality, low cost providers throughout the state. Both the products and the networks are referred to as High Value for Small Group employers and Blue Plus Minnesota Value for Individual & Family plans.

Blue Plus Southeast MN

Offered in the Individual & Family segment, the Blue Plus Southeast MN product has a coordinated-care network with Mayo Clinic which provides a personalized, coordinated approach to health care with primary and specialty care. This product uses the Blue Plus Southeast MN network.

Medicare Select Product

Medicare is primary for all services. For the highest level of benefits, all care must be provided or referred by the subscriber's primary care clinic. There are no benefits under the Medicare Select contract for services outside the network, although coverage through Medicare for eligible services is still available to the subscriber. Medical emergencies, however, are covered whether a subscriber is at home or traveling. The applicable Medicare deductible and coinsurance amounts are the subscriber's responsibility. Enrollment in Medicare Select is closed.

Blue Cross Medical Assistance Coverage Options

Minnesota Senior Health Options (MSHO) Secure BlueSM (HMO SNP)

Blue Plus offers a Minnesota Senior Health Options (MSHO) product called SecureBlueSM (MHO SNP) for dual eligible seniors. SecureBlue is a Special Needs Plan (SNP) offered under Medicare Advantage by Blue Plus. Blue Plus has a contract with both the Centers for Medicare and Medicaid Services (CMS) and the Minnesota Department of Human Services (DHS) that creates an alternative delivery system for acute and long-term care services and integrates Medicare and Medicaid funding.

SecureBlue combines the services and benefits of Medicare Parts A and B, including Part D prescription drug coverage, and Medicaid benefits.

A care coordinator will work closely with individual SecureBlue members to assist them in achieving optimal medical and social stability.

For SecureBlue members, Blue Plus is billed as primary not Medicare. SecureBlue members can be identified by ID numbers beginning with “MQS”. Enrollment eligibility may change monthly. Providers must verify eligibility through any electronic data system currently being used to access Medical Assistance eligibility, the Department of Human Services Eligibility Verification System (EVS), www.availity.com, or Blue Cross provider services, toll free at:1-866-518-8448.

SecureBlue is responsible for paying a total of 180 days of nursing home room and board. Some members are eligible for Elderly Waiver services. The only copays for SecureBlue members are for prescriptions. Members must designate a primary care clinic however, referrals are not required for services at participating providers. Services are coordinated through the members care coordinator. Providers should file their claims with Blue Plus

For complete information on Government Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

Families and Children and Minnesota Senior Care Plus (MSC+)/Blue Advantage

The Blue Advantage Families and Children and Minnesota Senior Care Plus (MSC+) are Minnesota Health Care Programs funded jointly by the state and federal governments. Families and Children is for enrollees under age 65. Blue Plus has a contract with DHS to provide services for Medicaid enrollees (MSC+ is for seniors 65+) in specific counties. MSC+ includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care.

Members can be identified by ID numbers beginning with “MQG” Enrollment eligibility may change monthly. Providers must verify eligibility through any electronic data system currently being used to access Medical Assistance eligibility, the Department of Human Services MN-ITS, www.availity.com, or Blue Cross provider services.

When enrolling into managed care, members designate a primary care clinic to provide or coordinate their care. If no clinic is selected, one will be assigned for them.

For questions, call the number on the back of the subscriber’s ID card, or call **1-800-711-9862**. Providers should file their claims with Blue Cross. Please refer to Chapter 3 of the Blue Plus Manual for more detailed information on Government Programs.

**MinnesotaCare
Program**

MinnesotaCare is a state-subsidized health program. It is funded by subscriber premiums, the state of Minnesota, a tax on health care providers and some federal matching dollars. It is open to all Minnesotans who meet program and income guidelines and do not have access to health insurance.

MinnesotaCare members can be identified by ID numbers beginning with “MQG”. Enrollment eligibility may change monthly. Providers must verify eligibility through any electronic data system being used to access Medical Assistance eligibility, the Department of Human Services MN-ITS, www.availity.com, or Blue Cross provider services.

Subscriber ID cards look similar to cards for Families and Children.

See Chapter 3 of the Blue Plus Provider Manual for more complete information.

Federal Employee Program

Federal Employee Program (FEP)

The Federal Employee Program (FEP), one of the health benefit plans available to federal government employees and their dependents, is administered by Blue Cross and Blue Shield plans throughout the country. Enrollment, eligibility, and claims records for all FEP subscribers are maintained in Washington, D.C. We have access to the records through a national telecommunications system.

The unique federal ID number, which always begins with an “R” and is followed by eight digits, identifies FEP subscribers.

Federal employees may choose Basic Option or Standard Option coverage. Providers should file all claims for FEP benefits within the local plan, (that is, Minnesota providers submit to Blue Cross and North Dakota providers submit to Blue Cross and Blue Shield of North Dakota).

Providers can call a new automated voice response unit (VRU) to check eligibility and benefits for FEP subscribers. To access this service, call **(651) 662-5044** or **1-800-859-2128**. Claim status is currently not available through the VRU.

Provider Statements

Your *Statement of Provider Claims Paid* and *Statement of Institutional Claims Paid* for FEP subscribers will be posted on a separate remit. You will also receive a separate check titled “Federal Employee Program” with the Blue Cross logo for your FEP subscribers. Recoupments and credit claim activities for FEP subscribers will be reflected on a separate Accounts Receivable Recoupment Report, which will be titled “Federal Employee Program.”

Benefit Changes

Visit www.fepblue.org for current benefit information.

United Concordia Dental

History

Medical/dental services eligible under member's medical plan will utilize the United Concordia Dental network effective for Individual, Commercial, Individual Medicare Advantage FEP and Employee plans.

Inquiries

888-587-2447

Delta Dental

History

Delta Dental of Minnesota offers access to Minnesota Select Dental Network. Delta Dental operates pursuant to an administrative service agreement with Blue Cross.

Dental services are provided through Delta Dental of Minnesota, which is independent from Blue Cross and Blue Shield of Minnesota. Delta Dental provides administrative services for dental benefits, including access to the Minnesota Select Dental network

Inquiries

Delta Dental inquiries may be directed to:

Delta Dental of MN
Professional Services Appeal and Grievance

P.O. Box 30416 Lansing, MI 48909

Phone: 1-800-774-9049, TTY: 711

Website: www.deltadentalmn.org

Prime Therapeutics LLC

Pharmacy Benefits Manager

Prime Therapeutics, LLC is Blue Cross' pharmacy benefits manager (PBM). The PBM works to maintain the highest standards in therapeutic safety and effectiveness and may offer both name brand and generic equivalents as well as specialty drugs.

Prime Therapeutics, LLC is an independent company providing pharmacy benefit management services.

Formularies

Blue Cross and Blue Plus offers formulary options to meet customer and subscriber needs. Check with your patient which formulary applies to their pharmacy coverage, or call Provider Service.

Workers' Compensation, No-Fault Auto & Subrogation

Overview

Following is a Question and Answer guide to assist you in reimbursement of Workers Compensation, No-Fault Auto and Subrogation claims.

Workers' Compensation, No-Fault Auto & Subrogation

1. **What does Blue Cross need if the workers' compensation carrier, or the automobile carrier/third-party liability carrier denies?**

We need a letter from the other carrier, stating the specific date of service on the claim they are wanting paid and the reason the other carrier is not paying claims.

2. **Why do claims deny when they are not marked work/auto/subro related?**

Once we have identified a workers' compensation or automobile or subrogation claim, an indicator is placed on the patient's file. All claims that are possibly related to the indicated injury are denied.

3. **Why do claims continue to deny when a denial has been sent in?**

The denial must be valid in order for Blue Cross to pay the claims under the health benefits. The denial is not valid unless it specifies why the other insurance carrier is denying and they provide a specific reason behind the denial such as doctor's opinion, IME, etc. If the denial is date specific, only the dates listed on the denial are adjusted.

4. **Why does Blue Cross need a denial from the workers' compensation carrier if the doctor states it is not work related?**

A notification from the workers' compensation carrier is needed if the treatment is similar to the work injury. The workers' compensation carrier must make the final determination.

5. **Why do some claims pay and some deny?**

If the diagnosis is non-specific (like pain in a limb) and we are unable to determine what is being treated the claim may deny. If we have limited information on what the injury is, some claims may pay while others may deny.

**Workers'
Compensation, No-
Fault Auto &
Subrogation
(continued)**

6. When does Blue Cross need chart notes to adjust claims?

The chart notes should indicate what the patient was treated for. If the chart notes indicate the treatment was not related to the work injury, the motor vehicle accident or the third-party accident, then claims can be adjusted. If chart notes are non-specific or treatment is similar to the accepted injury, a valid denial is needed from the other insurance carrier.

7. If there is an intervention case does Blue Cross pay claims?

Depending on the circumstances surrounding the litigation, Blue Cross may or may not pay claims. If you have case specific questions you should contact the Special Services Unit directly at **1-866-229-7398**.

8. If the subscriber has a pre-paid medical or MNCare group can we bill them?

No. As a provider you need to bill the other insurance carrier. If you do not know who the other insurance carrier is, then you must try to contact the subscriber three times for this information. If you are unable to get a response from the subscriber, then Blue Cross will adjust claims to pay, under the health benefit, once the documentation is received showing the three attempts to contact the subscriber.

9. What are the no-fault laws for Minnesota and surrounding states?

Minnesota and North Dakota have mandatory medical pay laws. This means all drivers insured in Minnesota or North Dakota have medical pay on their auto insurance. Minnesota has a \$20,000 medical pay limit. North Dakota has a \$30,000.00 medical pay limit. South Dakota, Iowa and Wisconsin are optional states which means the subscriber can choose to either have or not to have medical pay on their auto policy.

10. What are some uncommon injuries that may be covered by the workers' compensation carrier?

The workers' compensation carrier may cover injuries that occur when an employee trips or falls at work, is injured in the parking lot, is hurt volunteering or is hurt when traveling for work. If you have specific questions regarding a potential work related injury contact the Special Services Unit.

**Workers'
Compensation, No-
Fault Auto &
Subrogation
(continued)**

11. What are some uncommon injuries that maybe covered by the automobile or third-party insurance?

The automobile or third-party insurance may cover injuries that occur while the individual is at someone else's home, on someone else's private property, at a place of business, due to a dog bite, or when they are a pedestrian or bicyclist injured by a motor vehicle.

12. Does health insurance coordinate with auto/third-party or workers' compensation insurance?

No. In most circumstances the other insurance is primary. Once the other insurance carrier has exhausted their payments, claims may be payable under the health insurance policy.

13. Who should claims be filed to if the patient is working and has an auto accident?

The claims should first be filed to the workers' compensation carrier. If they deny stating the employee was not in the scope of their employment, then the claim should be filed to the auto insurance carrier. If the auto insurance carrier denies or benefits are exhausted, the claim should be billed to Blue Cross with a copy of both the workers' compensation denial and the auto carriers exhaust letter, EOB, or payment log.

14. What should be done if a claim was paid by both Blue Cross and another insurance company?

Option 1: Request a void/replacement claim. Refer to Chapter 10 for information regarding submission of void/replacement claims. Note that effective July 15, 2009, only out-of-state, nonparticipating providers are allowed to submit paper claim forms per Minnesota Statute 62J.536 and the Blue Cross provider contracts.

Information indicating if the patient's condition is related to employment, auto or other accident, or workers' compensation should be indicated on the replacement claim.

For professional claims (HICF-1500 or 837P) complete the items indicated below.

HICF 1500 Form Locator 837P				
Item #	Title	Loop ID	Segment	Notes
10a	Is Patient's Condition Related to: Employment	2300	CLM11	Titled Related Causes Code in the 837P

HICF 1500 Form Locator 837P				
Item #	Title	Loop ID	Segment	Notes
10b	Is Patient's Condition Related to: Auto Accident	2300	CLM11	Titled Related Causes Code in the 837P
10c	Is Patient's Condition Related to: Other Accident	2300	CLM11	Titled Related Causes Code in the 837P
10d	Reserved for local use	2300	K3	This is specific for reporting Workers' Compensation Condition Codes.
14	Date of Current Illness, Injury, Pregnancy	2300	DTP03	Titled in the 837P: a. Onset of current illness or injury date. b. Acute manifestation date. c. Accident date. d. Last menstrual period date.

For institutional claims (UB-04 or 837I) report the appropriate occurrence code. Occurrence codes and dates are entered in Form Locator(s) 31-34, 35-36 on the UB-04 or in Loop 2300 of the 4010A1 837I transaction. The following occurrence codes may be submitted as appropriate.

01:Accident/Medical Coverage

Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.

02: No-Fault Insurance Involved - Including Auto Accident/Other

Code indicating the date of an accident, including auto or other where state has applicable no-fault liability laws (that is, legal basis for settlement without admission or proof of guilt).

**Workers'
Compensation, No-
Fault Auto &
Subrogation
(continued)****03: Accident/Tort Liability**

Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.

04: Accident/Employment-Related

Code indicating the date of an accident allegedly relating to the patient's employment.

OPTION 2: Contact the Third Party Liability Unit at **1-866-251-6691** and request the claim is adjusted.

15. Should claims that are related to a work/auto/third-party injury be billed to Blue Cross?

Claims that are related to a work/auto/third-party injury should be billed to the liable insurance carrier and not to Blue Cross. If the other insurance carrier denies, then the claim should be billed to Blue Cross with a copy of the other insurance carrier's denial and/or EOB attached.

On occasion the other insurance carrier may not process the claim in a timely manner and due to Blue Cross timely filing guidelines, you may need to bill to Blue Cross prior to getting an EOB or denial from the other carrier. If this occurs, you should submit the claim to Blue Cross and note in the HICF 1500, form locator 10 or the 837P for professional claims (as noted under 14. above) or the appropriate occurrence code for institutional claims. Occurrence codes and dates are entered in Form Locator(s) 31-34, 35-36 on the UB-04 or in Loop 2300 of the 4010A1 837I transaction.

16. How can I reach the Special Services Unit if I have other questions or concerns related to a work/auto/third-party injury?

The Third Party Liability Unit can be reached by direct dial at **1-866-251-6691**, Monday through Thursday 8:00 am - 4:30 pm, Friday 9:00 am - 4:30 pm, CT.

Networks: The following is a summary of the largest networks currently in effect. It is not an all-inclusive list of all networks

Aware®	An extensive open-access network that includes nearly every physician and hospital in Minnesota. This network is used with major medical plans and open access/preferred provider-type products.
High Value / Blue Plus Minnesota Value	A statewide network featuring high quality, low cost providers. For Large Group and Small Group employers, the network is referred to as High Value. In the individual market, the network is referred to as Blue Plus Minnesota Value.
BlueCard® PPO	A national network managed by the Blue Cross and Blue Shield Association. Local Blue plans can sell national account business by leveraging the 50-state Blues provider network.
BlueCard® Traditional	A national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.
BlueCard® Managed Care/POS	A health benefit program that covers employees of national companies who are living in Minnesota. The highest level of benefits is received when members obtain services from their primary care provider/group and/ or comply with referral and/or authorization requirements for care. Substantial benefits are still provided when members obtain care from any eligible provider without referral or authorization, according to the contract terms.
Global Core® (formerly BlueCard Worldwide®)	Global Core® is a medical assistance program connecting subscribers traveling or living outside the United States, Puerto Rico and U.S. Virgin Islands to a network of hospitals and healthcare professionals around the world. Through the Global Core Service Center, the program provides subscribers with claims support, referrals to providers, translation services, and medical monitoring 24 hours a day, 365 days a year.
Blue Distinction Centers®	<p>A national centers of excellence program that enables subscribers to make more informed health care decisions to improve outcomes. Facilities must meet strict clinical criteria to earn the Blue Distinction Centers designation.</p> <p>Note: Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered, please call Blue Cross.</p>

Chapter 6

Blue Plus

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Subscriber Information

Introduction to Blue Plus®

This chapter was developed for all Blue Plus Providers and their business staff. The information contained in this chapter will give the referral (specialty care) Providers access to Blue Plus information. The Blue Plus Provider Manual for participating primary care clinics (PCCs) details the information necessary for the PCC to conduct business with Blue Plus and is intended as a complement to this manual.

Blue Plus, an affiliate of Blue Cross and Blue Shield of Minnesota, is a state-certified health maintenance organization (HMO). In most Blue Plus plans, Subscribers select a participating PCC that coordinates the Subscriber's medical care and authorizes treatment by specialists when necessary.

Because Blue Plus is an affiliate of Blue Cross and Blue Shield of Minnesota, Blue Plus is subject to most of the same policies and procedures as Blue Cross and Blue Shield of Minnesota.

Blue Plus Network Participation

To be listed as a participating Blue Plus Provider, Providers need to have a signed Blue Plus Referral Health Professional Provider Service Agreement. After participation is established in the Aware® network, Providers can make a written request for a Blue Plus Referral Health Professional Provider Service Agreement. Send this request to:

Blue Cross and Blue Shield of Minnesota
Blue Plus Contracting
P.O. Box 64560
St. Paul, MN 55164-0560

Blue Plus will review the request and make a written response.

Note: Blue Plus will not offer Blue Plus Referral Health Professional Provider Service Agreements to all requesting health care providers.

Department of Health

The Minnesota Department of Health (MDH) regulates HMOs licensed in Minnesota. It governs the fully insured HMO products, which includes Blue Plus. The MDH is involved in approving and monitoring contract changes, provider network access and changes, appeals, identification cards, quality improvement, and much more.

Subscriber Rights and Responsibilities**Blue Plus Subscriber Rights and Responsibilities. Blue Plus Subscribers receive the following statement of rights:****Your rights as a health plan member:**

- To be treated with respect, dignity and privacy.
- To receive quality health care that is friendly and timely.
- To have available and accessible medically necessary covered Health Services, including emergency services, 24 hours a day, seven (7) days a week.
- To be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment
- To participate with your health care providers in decisions about your treatment.
- To give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity).
- To name the person who can make health care decisions for you in the event of your incapacity.
- To refuse treatment.
- To have privacy of medical and financial records maintained by Blue Plus and its health care providers in accordance with existing law.
- To receive information about Blue Plus, its services, its providers, and your rights and responsibilities.
- To make recommendations regarding Blue Plus' rights and responsibilities policies.
- To have a resource at Blue Plus or at the clinic that you can contact with any concerns about services.
- To file a complaint with Blue Plus and the Commissioner of Health and receive a prompt and fair review.
- To initiate a legal proceeding when experiencing a problem with Blue Plus or its providers.

**Subscriber Rights and Responsibilities
(continued)**

- Medicare enrollees have the right to voluntarily disenroll from Blue Plus. Blue Plus may not encourage or request you to disenroll except in circumstances specified in federal law.
- Medicare enrollees have the right to a clear description of nursing home and home health care benefits covered by Blue Plus.

You have the responsibility as a health plan member:

- To know your health plan benefits and requirements.
- To provide, to the extent possible, information that Blue Plus and its providers need in order to care for you.
- To participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- To follow the treatment plan prescribed by your provider or to discuss with your provider why you are unable to follow the treatment plan.
- To provide proof of coverage when you receive services and to update the clinic with any personal changes, such as name and address.
- To pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered.
- To keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

**Subscriber Rights and Responsibilities
(continued)****Minnesota Health Care Programs member Rights and Responsibilities:**

You have the right to know about your rights and responsibilities. If you have any questions, please call member services at **(651) 662-5545** or toll free at **1-800-711-9862**.

Your rights as a health plan member:

- To get quality health care that's timely, accessible, and friendly.
- To be treated with respect, dignity and consideration for privacy.
- To get medically necessary covered services, including emergency services 24 hours a day, seven (7) days a week.
- To be told about your health problems.
- To get information about treatment, your treatment choices and how they may help or harm you – whether or not the health plan would pay for these treatments.
- To participate with your providers in the decisions about your health care.
- To participate in understanding your health problems and developing your treatment goals.
- To refuse treatment. To get information about what might happen if you refuse treatment.
- To refuse care from specific providers.
- To expect that we will keep your medical and financial records private.
- To request and receive a copy of your medical records. You also have the right to ask to correct the records.
- Get notice of our decisions if we deny, reduce, or stop a service, or deny a payment for a service.
- To file a grievance or appeal with Blue Plus. You can also file a complaint with the Minnesota Department of Health.
- To request a State Fair Hearing with the Minnesota Department of Human Services (also referred to as “the State”). You may request a State Fair Hearing after exhausting the Blue Plus appeal process. The State Fair Hearing must be requested no later than 120 days from the appeal decision.
- To get a clear explanation of covered nursing home and home care service.

Subscriber Rights and Responsibilities (continued)

- Give written instructions that inform others of your wishes about your health care. This is called a “health care directive.” It allows you to name a person (agent) to decide for you if you are unable to decide, or if you want someone else to decide for you.
- To choose where you will get family planning services.
- To get a second opinion for medical, mental health and chemical dependency services.
- To be free of constraints or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request a copy of the Certificate of Coverage at least once a year.
- To recommend changes regarding Blue Plus’ rights and responsibilities policies.
- To freely exercise your rights. The exercise of your rights will not badly affect the way you are treated.
- Get the following information from us, if you ask for it:
 - Whether we use a physician incentive plan that affects the use of referral services;
 - The type(s) of incentive arrangement used;
 - Whether stop-loss protection is provided; and
 - Results of member survey if one is required because of our physician incentive plan.
- Get the results of an external quality review study from the State, if you ask for them.
- To be told when a health care provider cancels their contract with Blue Plus. You may choose from the rest of the Blue Plus providers.
- To have a person at Blue Plus or at the clinic to contact with any concerns about services.
- To get information about Blue Plus, our services, network of providers and your rights and responsibilities.

Subscriber Rights and Responsibilities (continued)

- To start a legal proceeding when having a problem with Blue Plus or our providers.
- To file a grievance or appeal with Blue Plus and receive a prompt and fair review.
- To contact the State ombudsman for help in filing a grievance or appeal.
- To ask for a speedy hearing.

Your responsibilities as a health plan member:

- Read your Certificate of Coverage and know which services are covered under the Plan and how to get them.
- To show your Blue Plus member ID card and your Minnesota Health Care Programs card every time you go for health care. Also show the cards of any other health coverage you have, such as Medicare or private insurance.
- To establish a relationship with a Blue Plus primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
- To give information that Blue Plus and our providers need to give care to you. Share information about your health history.
- To follow all your doctor's instructions. If you have questions about your care, you should ask your doctor.
- Work with your doctor to understand your total health condition. It is important to know what to do when a health problem occurs, when and where to seek help, and how to prevent health problems.
- To practice preventive health care. To have tests, exams and shots recommended for you based on your age and gender.
- To tell the clinic about changes in your name or address.
- To keep appointments for care or to give early notice if you need to cancel.

This information is available in other forms to people with disabilities by calling Blue Plus customer service at (651) 662-5545, toll free at 1-800-711-9862 (voice), or (651) 662-8700 or 1-888-878-0137 (TTY), or 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech-to-speech relay service).

Subscriber Benefits

Subscribers' benefits depend upon their type of contract. Benefits for Blue Plus' standard fully insured contracts may vary from self-insured contracts. Because Subscribers' benefits will vary, please use BLUELINE, www.availity.com, or contact provider services for specific Subscriber benefits.

- **Highest level of benefits** – Subscribers generally receive the highest level of benefits when they receive their services from their PCC or when the PCC authorizes a referral to a specialist. A list of participating referral providers which is online at www.availity.com is available in the Referral Network for PCCs directory or at bluecrossmn.com.
- **Self-referral** Subscribers may decide to manage their own health care without involving their PCC. Blue Plus considers this a self-referral. In doing so, Subscribers usually take on additional financial responsibilities. A claim may be paid at a lesser benefit or completely denied, depending on if the Subscriber has a self-referral option.
- **Referral bypass** – There are some Health Services that will be paid at the highest level of the Subscriber's benefits without a referral from the PCC. This is known as a referral bypass or referral exception. For a listing of referral bypasses, please refer to the Referral Not Required section of this chapter.
- **PCC/Care System - Referral bypass-** There may be situations where a particular PCC or care system has communicated their wish to have a referral bypass implemented for a particular situation. This allows the specified Health Service to be paid at the highest level of benefits without the Provider communicating a referral to Blue Plus. For additional information regarding a PCC specific referral bypass, please contact provider services. These requests are handled on an individual basis and must be implemented by Blue Plus and the PCC.
- **Open access** – Some Subscriber Contracts have open access for specified Health Services. The Subscriber usually uses a designated participating network provider and will receive the highest level of benefits without a referral from the PCC. Some examples include vision, chiropractic, obstetrics/gynecology (ob/gyn), or behavioral health care.

Subscriber PCC Selection

Subscribers are responsible for selecting their primary care clinic (PCC). Every member in the family may select their own PCC; they are not required to select the same PCC. Subscribers may also change their designated PCC. To do so they must contact Blue Plus customer service. The phone number is on the back of the Subscriber's ID card.

The effective date assigned to all PCC changes will be generally the first day of the month following Blue Plus's receipt of the request. This provision may be waived under certain situations.

The effective date of the change will be communicated on the instructions mailed with the-Subscriber's ID card.

Claim Processing

When a claim is received for specialty care (not by the PCC), Blue Plus will review ITS records for a referral. If a referral has not been received or does not match an open referral in Blue Plus' records, Blue Plus will process the claim as a self-referral if the Subscriber has a self-referral option. If the Subscriber does not have a self-referral option, Blue Plus may contact the PCC to inquire if a referral is desired. If no referral is authorized, then the claim will be denied or processed at the lower level of benefits.

Statement of Provider Claims Paid Form

Providers will be notified of claims processing details as outlined in *Chapter 10-Reimbursement/ Reconciliation Programs* of this manual for more details regarding the Blue Plus *Statement of Provider Claims Paid* and reimbursement.

Quality of Care Complaint

A quality of care complaint is an additional right of Blue Plus Subscribers. Subscribers may complain if they feel the quality of their care has been reduced. Some examples of quality of care complaints are listed below. Subscribers may file a complaint if they believe:

- They are not receiving an appointment in a reasonable amount of time
- The PCC is not referring them to a specialist when it is necessary
- The Provider/Provider office was rude or discourteous
- The Provider is unable to diagnosis or treat their condition

Blue Plus immediately supplies the Provider with a copy of the complaint and involves the Provider in the solution. Blue Plus is required by the Department of Health to complete these complaints in 30 days, therefore; Blue Plus requires the Provider's expedited attention to any request it may have.

Referrals

Overview

When Blue Plus Subscribers are referred by their PCC to other providers, Blue Plus needs to be notified by the PCC in order for claims to process correctly. **A referral is not a guarantee of payment, but allows the Subscriber to seek medical care outside the PCC.** A referral does not negate the necessity of a prior authorization or preadmission notification, if they are required. Referrals are in addition to both of these procedures for managed care products.

Once the referral is received from the PCC, Blue Plus will generate a referral letter depending on the type of referral (see *Referral Letter*).

It is the referred provider's responsibility to communicate medical assessments and proposed treatment plans to the PCC. To best coordinate the Subscriber's care, the PCC must have complete medical information. PCCs may request the information in the format of their choice.

Referral Policy

The referral process occurs when a PCC determines that the Subscriber's condition requires care outside his or her PCC. A referral is initiated by the PCC and is limited to a specific duration and number of visits, as determined by the PCC. There are some situations where a referral is not required (see *Referrals Not Required*). A prior authorization may be necessary. See the section on Prior Authorization, Section 6-16. Policies for Government Programs may have different requirements. See Chapter 3 in the Blue Plus Provider Manual.

The goal of the referral process is to ensure continuity of care through coordination with the PCC. When care needs are identified which cannot be appropriately provided by the PCC, care is referred.

The objectives of referrals are:

- To promote coordination of care and communication between Subscribers, PCCs and specialty providers.
- To promote appropriate use of referral care, thereby reducing under-utilization or over-utilization of services.
- To promote seamless, quality of care delivery by facilitating the use of a select, coordinated network of primary care and specialty providers.

Referral Points

Remember these important points about referrals:

- PCCs must have an established referral process.
- PCCs must notify Blue Plus of authorized referrals via the **www.availity.com** product at **www.availity.com**.
- The Subscriber may receive Health Services only from the clinic named in the referral or standing referral.
- The referral provider or specialist may not refer Subscribers to other providers without written consent from the PCC. If no referral is given, Subscribers will be responsible for any reduced benefits. Exceptions are made for Minnesota Health Care Program Subscribers.
- In some cases, Blue Plus will request a second referral if information from the referred provider's claim does not match information received on the initial referral.
- If a Subscriber who has a referral or standing referral changes PCCs, the referral or standing referral will no longer be valid as of the date of the PCC change. The Subscriber's new PCC must now coordinate the Subscriber's care.

Referral Required

If the PCC authorizes the care outside the PCC, referrals are required to be communicated to Blue Plus for:

- Home health care/home IV
- Outpatient surgery
- Psychological testing submitted with a medical diagnosis
- Visits to a specialty provider
- Inpatient admissions – including hospitals
- Inpatient hospital admissions – a referral will be assumed when the preadmission notification is completed, if the admitting physician is from the Subscriber's PCC

There are times when a referral is appropriate for behavioral Health Services. If this is the case, Providers may call Provider Services at **1-800-262-0820** or local **(651) 662-5200** to discuss referral needs. This phone number may also be used to see which providers are in the behavioral health network. Minnesota Health Care Program Subscribers have direct access to network providers. In rare instances, out-of-network exceptions may be considered. Call the above numbers for further information.

There also may be exceptions in situations where the Subscriber has open-access benefits for a particular type of Health Services.

For complete information on Government Programs requirements, please refer to Chapter 3 in the Blue Plus Provider Manual.

Referral Not Required

Blue Plus does not require referrals for the Health Services listed below. Claims will process at the highest level of coverage, as if they were referred, without the PCC authorizing a referral. This process is known as a referral bypass or referral exception. The referral bypasses may be in place for ease of administration, legislative mandate or both. They may vary by Subscriber Contract or PCC. For complete information about Minnesota Health Care Programs requirements, see Chapter 3 in the Blue Plus Provider Manual.

- Abortion and sterilization
- Allergy serum when injection is done in the PCC
- Ambulance transportation
- Anesthesia and assistant surgeon, if medically necessary (if the outpatient surgery or inpatient admission is referred)
- Covered services by dentists, endodontists, periodontists, orthodontists, prosthodontists, and oral and maxillofacial surgeons.
- Diagnostic X-ray and laboratory services only (except MRI)
- Durable medical equipment (DME)
- Emergency services
- Inpatient consultation (if the inpatient admission is referred)
- Inpatient consultation (if the inpatient admission is referred)
- Inpatient delivery/maternity, and related services, including prenatal and complications of pregnancy
- Inpatient treatment of a medical emergency
- Magnetic Resonance Imaging (MRI)

**Referral Not Required
(continued)**

- One postpartum home care visit, if the visit follows an early discharge. Early discharge for a vaginal delivery would be within 48 hours of delivery and, for C-section, within 96 hours of delivery
- Oral and maxillofacial surgeons
- Orthodontists
- Outpatient emergency room services and associated services
- Outpatient observation room
- Prescription drug (pharmacy)
- Services for the diagnosis of infertility
- Testing and treatment of a sexually transmitted disease
- Testing for AIDS or other HIV-related conditions
- Voluntary planning of the conception and bearing of children

PCCs may contact Blue Plus to implement a PCC-specific referral bypass for their managed care Subscribers. This is beneficial when a PCC continually refers to a specific provider.

Standing Referral

Minnesota law provides for a standing referral. Standing referrals are for longer-term, ongoing care by a specialty provider. They may be established at any time at the PCC's discretion. Referrals must be communicated to Blue Plus prior to Health Services being rendered. PCCs determine the number of referral visits and the length, up to 365 days.

Mandatory standing referrals to a specialist qualified to treat the specific condition must be granted, upon request, to a Subscriber with any one of the following conditions.

- A chronic health condition
- A life threatening mental or physical condition
- Pregnancy beyond the first trimester if the Subscriber's plan does not offer open access benefits to ob/gyn providers in the Subscriber's network
- A degenerative disease or disability
- Any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist

Routine standing referrals are still at the discretion of the PCC. PCCs are not required to authorize a referral to accommodate personal preference, convenience, or other non-medical reason. While mandatory-standing referrals must be provided, the PCC can determine the total number of visits within the 12-month period based on the Subscriber's medical condition. If the PCC has the specialist within its clinic/care system, the PCC may request that the Subscriber receive services there. PCCs must communicate referrals to Blue Plus prior to referred services being rendered.

This law permits specialists, in agreement with the Subscriber and PCC, to provide primary care services, authorize tests and Health Services, and even make secondary referrals. If the PCC does not grant the Subscriber's standing referral request, the PCC should inform the Subscriber that he or she can file a complaint with Blue Plus by calling the telephone number on the back of the Subscriber ID card.

Clarifications of Terms Clear communication between Blue Plus, the PCC, specialist, and the Subscriber is very important. At times, definitions and understanding of words may differ. To best serve Subscribers, a clear understanding of the meaning of the terms referral, prior authorization, and preadmission notification is necessary. Listed are some clarifications and further explanations that are helpful to fully understand.

Referral:

- A referral is the authorization from the PCC for its Subscriber to seek medical care outside the PCC and receive the highest level of the Subscriber's benefits.
- A referral does not mean the Health Service is approved for admission notification or prior authorization, which is separate from the referral process.
- A referral does not mean the Health Service is eligible under the Subscriber's Contract. Even if the Health Service is referred, it must be eligible under the Subscriber's Contract to be eligible for reimbursement.
- Subscribers may think that a Health Service is referred if the Provider tells them the Health Service is Medically Necessary. Be clear when referring to Health Services.
- A denied referral does not mean that the Health Service is not Medically Necessary. It may simply mean that the PCC may be able to handle the Health Service within its clinic/care system or at a different referral provider with which the PCC has developed a relationship.
- Referrals are not created by Blue Plus. Referrals from one provider to another are established standard practice. Blue Plus simply requests to be communicated with so that claims may be processed correctly. For complete information about Minnesota Health Care Programs, see Chapter 3 of the Blue Plus Provider Manual.
- A verbal referral is not sufficient. If the PCC authorized a referral, it needs to be communicated to Blue Plus (unless a referral bypass is in place).
- Referrals should be authorized to the entity billing for the Health Service (for instance, practice, facility or contracting provider), not the Health Care Practitioner who is performing the service.

**Clarifications of Terms
(continued)****Prior Authorization:**

- A prior authorization does not mean that the Health Service is referred. If a prior authorization is required and a provider other than the PCC is performing the Health Service, a referral is also required.
- An approved prior authorization does not mean the Health Service is covered under the Subscriber's plan. Subscribers' benefits may change.

Admission Notification:

- An admission notification does not mean the Health Service is referred. If an admission notification is required and the PCC wishes the Health Service to be referred, a referral must be done in addition to the admission notification. However, when an admission notification is communicated to Blue Plus for an inpatient hospital stay and the admitting physician is part of the Subscriber's PCC, Blue Plus will assume that a referral is authorized.

Referral Letter

Referral letters are sent as described below. The reverse side of the referral letter may be used by the specialist to communicate to the PCC the results of the services provided.

If the referral is...	Then...
To a specialist (not within the PCC)	a copy is sent to: <ul style="list-style-type: none"> • The referral specialist only if they do not have access to www.availity.com • The Subscriber, and • PCC only if it does not have access to www.availity.com
For an outpatient procedure	a copy is sent to: <ul style="list-style-type: none"> • The Subscriber, and • PCC only if it does not have access to www.availity.com
For an inpatient procedure	no copies are mailed

**Referral Letter
(continued)**

Please note that if the PCC or the referred specialist has access to **www.availity.com**. Referral letters will not be mailed because they have access to the information electronically.

[Date]

Patient Referral Notice

[Name of patient]

Patient:

[Address of patient]

Identification #:

Copy to:

Member #

[Name of secondary provider]

Relation to subscriber:

Sex: Date of Birth:

Group #

Referral #

Dear [name of patient]

This letter is to confirm that your primary care clinic has requested a referral for you to [insert provider name], for care to be received from _____ through _____, up to a maximum of _____ visits.

Your Blue Cross/Blue Plus health plan will pay for its share of the health services described above, as defined by the terms of your health plan contract, provided that:

1. Your primary care clinic has requested a referral (this letter confirms that this requirement has been met); and
2. You are otherwise eligible to receive health plan benefits (for example, you are a currently enrolled member, you have not reached a lifetime or benefit maximum, and your contract covers the services provided).

Here is a list of other conditions that apply. If you have questions, please call the customer service number on the back of your health plan member ID card.

- A new referral request must be submitted by your primary care clinic for any care outside the dates listed or for more than the maximum number of visits noted above.
- This referral is valid only for care provided by [insert provider name].
- If you change your primary care clinic, this referral is no longer valid.
- Any health services related to services excluded in your contract (for example, benefit exclusions or investigative services) are not covered, even if ordered or provided by your primary care clinic or the provider to whom you have been referred.

This referral has been made by: Physician: Primary Care Clinic: Clinic Provider #:	Referral care must be provided by: Provider name: Provider #:
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TO THE REFERRAL SPECIALIST

You or the primary care clinic must approve any hospitalization, tests or special treatments. Check with the referring physician to determine the participating hospital the clinic uses. Do not place yourself or the patient at financial risk by performing services not eligible for coverage under the patient's health plan, outside the dates specified or for more than the number of visits approved on this referral, or by admitting to a facility not authorized by the referring physician.

Special instructions from the referring physician:

Please use the space below to provide a written report of services to the referring physician at:
[address of referring physician]

Special Benefits

Overview	This section details some of the special benefits for Blue Plus. It will assist in answering questions regarding the benefits. Information in this Provider Policy & Procedure Manual is a general outline. Provider Service Agreements and Subscriber Contracts determine benefits.
Chiropractic Benefits	Most Subscribers have open-access to a Select Network chiropractor. They may receive eligible chiropractic services without a referral from their PCC. To receive the highest level of the Subscriber's benefits, the Subscriber must use a chiropractor in the Select Network.
Continuity of Care After Facility Discharge	<p>Patient care can easily become fragmented and compromised as patients pass from a hospital/facility stay back to the care of their primary care provider. The Joint Commission has two Continuum of Care standards that directly address the follow-up care process of patients that are discharged. The Joint Commission states that the need for appropriate follow-up plans include:</p> <ul style="list-style-type: none"> • Providing continuing care based on the patient's needs • Exchanging of appropriate information when a patient is accepted, referred, transferred, or discharged to receive further care or services <p>The National Committee for Quality Assurance (NCQA) standards require that managed care organizations monitor the continuity and coordination of care that Subscribers receive across practices and provider sites. A smooth transition and continuity of care after discharge is a need and challenge in every episode of care. Re-admissions can be caused by gaps in the follow-up process.</p>
Continuity of Care After Facility Discharge (continued)	<ul style="list-style-type: none"> • Subscriber role: Subscribers must identify a PCC or follow-up provider that will coordinate their care after facility discharge. • Hospital/facility role: Hospitals/facilities are encouraged to develop systems that capture and communicate the PCC, share information in a timely manner with the follow-up provider after discharge, provide the Subscriber with instructions for care after discharge, educate the Subscriber as needed, and obtain permission from the Subscriber to share information with the follow-up provider. • PCC or follow-up provider role: PCCs or follow-up providers need a process in place to receive and file medical information into a patient's clinic chart in a timely manner.
Durable Medical	Subscribers can use any DME Provider in the applicable Blue

Equipment

Cross and Blue Shield of Minnesota network.

Behavioral Health and Chemical Dependency Services

Blue Plus Subscribers may coordinate their evaluation/management (E/M) or medication management services for behavioral Health Services through their PCC or a behavioral health provider in their network. E/M and medication management services performed by another provider will require a referral from the Subscriber's PCC in order to receive the highest level of benefits.

Most Subscriber Contracts do not require referrals for claims to process at the highest level. However, Subscriber Contracts that require the Subscriber to stay in the Select behavioral health network require authorization from Blue Plus to see a provider outside of that network. PCCs do not need to initiate referrals for Subscribers requiring mental health/chemical dependency care.

Open Access to OB/GYN Health Services

State legislation provides for many Subscribers to seek specified ob/gyn Health Services without a referral from a PCC. The benefit would be detailed in the Subscriber Contract. When a Subscriber requires those specified ob/gyn Health Services, she may go to her PCC or elect to seek care directly from any ob/gyn provider in her network without being referred by the PCC and receive the highest level of her benefits. This benefit is effective for fully-insured groups. This benefit is optional for self-insured groups.

- **Eligible open access ob/gyn Health Services:** The Subscriber may go to any ob/gyn provider in her network for any of the Health Services listed below in the "Specified Codes for Open Access OB/GYN Health Services" section.

Necessary Health Care beyond OB/GYN Health Services

Direct access does not extend beyond ob/gyn Health Services. If a Subscriber who has directly accessed ob/gyn Health Services requires specialized health care beyond the specified open-access ob/gyn benefits, the Subscriber must be directed back to her PCC or be referred by her PCC in order for the care to be coordinated.

For example, if the ob/gyn provider identifies ovarian cancer and the Subscriber needs to see an oncologist, the Subscriber must be directed back to her PCC because the Subscriber Contract may not allow for self referral to an oncologist and in most cases, a referral provider may not refer to another referral provider. The open access benefit is only for Health Services provided by ob/gyn providers.

For those Subscribers who have an open access benefit, eligible inpatient and outpatient hospitalization and related ob/gyn Health Services are covered at the Subscriber's highest benefit level. In such cases, the ob/gyn provider must coordinate the ob/gyn Health Services. Blue Plus may not be able to identify these claims during initial processing. Adjustments to claims may be requested by calling Provider Service.

Specified Codes for Open Access OB/GYN Health Services

Claims submitted with the following codes by an-ob/gyn provider do not require a referral if the Subscriber has ob/gyn open-access benefits and the Provider is in the Subscriber's network.

Note: All diagnoses must be reported to the highest specificity.

OB/GYN Open Access Diagnosis

Diagnosis (DX) Code	Description
054.0-054.19 (ICD-9-CM) A60.00- A60.01, A60.04, A60.09, B00.0 (ICD-10-CM)	Herpes simplex
078.81-078.89 (ICD-9-CM) A88.1, A74.89, B33.8, R11.11 (ICD-10-CM)	Other diseases due to viruses and Chlamydiae

	Diagnosis (DX) Code	Description
OB/GYN Open Access Diagnosis (continued)	079.4 (ICD-9-CM) B97.7 (ICD-10-CM)	Human papillomavirus
	079.81, 079.89 (ICD-9-CM) A74.89, B33.4, B34.3, B34.8, B97.21, (ICD-10-CM)	Other specified viral and chlamydial infections
	099.0-099.9 (ICD-9-CM) A63.8, A64, A65, A66.19, A66.2, A66.3, A66.4, A66.8, A67, A68, M02.30, N34.1, (ICD-10-CM)	Syphilis and other venereal disease
	112.0-112.9 (ICD-9-CM) B37.0-B37.3, B37.49, B37.5-B37.7, B37.81-B37.82, B37.84, B37.89, B37.9 (ICD-10-CM)	Candidiasis

**OB/GYN Open Access
Diagnosis (continued)**

Diagnosis (DX) Code	Description
127.4 (ICD-9-CM) B80 (ICD-10-CM)	Enterobiasis
131.00-131.9 (ICD-9-CM) A69.00-A69.03, A69.09, A69.8-A69.9 (ICD-10-CM)	Trichomoniasis
132.2 (ICD-9-CM) B85.3 (ICD-10-CM)	Phthirus pubis
174.0-184.9 (ICD-9-CM) C50.11-C57.9 (ICD-10-CM)	Malignant neoplasm
217-221.9 (ICD-9-CM) D24.9-D28.9 (ICD-10-CM)	Benign neoplasm
233.0-233.9 (ICD-9-CM) D05.90-D09.19 (ICD-10-CM)	Carcinoma in situ of breast and genitourinary system

**OB/GYN Open Access
Diagnosis (continued)**

Diagnosis (DX) Code	Description
236.0-236.99 (ICD-9-CM) D39.0-D41.9 (ICD-10-CM)	Neoplasm of uncertain behavior of genitourinary system
239.3 (ICD-9-CM) D49.3 (ICD-10-CM)	Neoplasm of unspecified nature of breast
239.5 (ICD-9-CM) D49.5 (ICD-10-CM)	Neoplasm of unspecified nature of other genitourinary organs
256.0-256.9 (ICD-9-CM) E28.0-E28.9 (ICD-10-CM)	Ovarian dysfunction
599.0 (ICD-9-CM) N39.0 (ICD-10-CM)	Urinary tract infection, site not specified
610.0-611.9 (ICD-9-CM) N60.01-N64.9 (ICD-10-CM)	Disorders of breast
614.0-616.9 (ICD-9-CM) N70.01-N73.9 (ICD-10-CM)	Inflammatory disease of female pelvic organs
617.0-627.9 (ICD-9-CM) N80.0-N95.9 (ICD-10-CM)	Other disorders of female genital tract, infertility

**OB/GYN Open Access
Diagnosis (continued)**

Diagnosis (DX) Code	Description
630-677 (ICD-9-CM) O01.0-O94.9 (ICD-10-CM)	Complications of pregnancy, childbirth and the puerperium
698.1 (ICD-9-CM) L29.3 (ICD-10-CM)	Pruritus of genital organs
752.0-752.9 (ICD-9-CM) Q50.39-Q55.9 (ICD-10-CM)	Congenital anomalies of genital organs
780.01-780.99 (ICD-9-CM) R40.0-R68.89 (ICD-10-CM)	General symptoms
788.0-788.9 (ICD-9-CM) N23, R30.0-R39.9 (ICD-10-CM)	Symptoms involving urinary system
789.1-789.9 (ICD-9-CM) R16.0-R19.8 (ICD-10-CM)	Other symptoms involving abdomen and pelvis
795.00-795.79 (ICD-9-CM) R76.0-R87.619 (ICD-10-CM)	Nonspecific abnormal histological and immunological findings
996.32 (ICD-9-CM) T83.39xA , T83.39xD, T83.39xS (ICD-10-CM)	IUD complications

**OB/GYN Open Access
Diagnosis (continued)**

Diagnosis (DX) Code	Description
V01.6 (ICD-9-CM) Z20.2 (ICD-10-CM)	Contact with or exposure to venereal diseases
V07.4 (ICD-9-CM) Z79.890 (ICD-10-CM)	Postmenopausal hormone replacement therapy
V10.3 (ICD-9-CM) Z85.3 (ICD-10-CM)	Personal history of malignant neoplasm breast
V10.40- V10.44 (ICD-9-CM) Z85.40-Z85.44 (ICD-10-CM)	Personal history of malignant neoplasm female genital organs
V13.21- V13.29 (ICD-9-CM) Z87.410- Z87.412, Z87.42, Z87.51 (ICD-10-CM)	Personal history of pre-term labor Other genital system and obstetric disorders
V15.7 (ICD-9-CM) Z92.0 (ICD-10-CM)	Other personal history presenting hazards to health-contraception
V16.3 (ICD-9-CM) Z80.3 (ICD-10-CM)	Family history of malignant neoplasms of breast

**OB/GYN Open Access
Diagnosis (continued)**

Diagnosis (DX) Code	Description
V16.40- V16.49 (ICD- 9-CM) Z80.41-Z80.49 (ICD-10-CM)	Family history of malignant neoplasms of genital organs
V22.0-V28.9 (ICD-9-CM) Z34.00-Z36 (ICD-10-CM)	Normal pregnancy Supervision of high-risk pregnancy Postpartum care and examination Contraceptive management Procreative management Outcome of delivery Antenatal screening
V45.51- V45.52 (ICD- 9-CM) Z97.5(ICD-10- CM)	Presence of intrauterine contraceptive device Intrauterine contraceptive device Presence of subdermal contraceptive implant
V61.5-V61.7 (ICD-9-CM) Z46.0, Z46.1 (ICD-10-CM)	Multiparity Illegitimacy or illegitimate pregnancy Other unwanted pregnancy
V67.00-V67.9 (ICD-9-CM) Z08, Z09 (ICD-10-CM)	Follow-up examination
V70.0-V70.9 (ICD-9-CM) Z00.00-Z00.8 (ICD-10-CM)	General medical examination

	Diagnosis (DX) Code	Description
OB/GYN Open Access Diagnosis (continued)	V71.5 (ICD-9-CM) Z04.41 (ICD-10-CM)	Observation following alleged rape or seduction
	V72.31- V72.42 (ICD-9-CM) Z01.419, Z01.42, Z32.00- Z32.01. Z32.02 (ICD-10-CM)	Gynecological examination Pregnancy examination or test, pregnancy unconfirmed
	V74.5 (ICD-9-CM) Z11.3 (ICD-10-CM)	Special screening examination for venereal disease
	V76.10- V76.19 (ICD-9-CM) Z12.31, Z12.39 (ICD-10-CM)	Special screening for malignant neoplasms of breast
	V76.2 (ICD-9-CM) Z12.4 (ICD-10-CM)	Special screening for malignant neoplasms of cervix

Vision Care

Fully insured Subscribers have direct access to general eye care Health Services rendered by optometrists and ophthalmologists in the participating network. Appropriate ophthalmologist Health Services including eye examinations and Evaluation and Management (E/M) procedure codes as well as CPT codes 65205, 65210, 65220, 65222, and 68761 are eligible. Some self-insured groups also include this benefit. Major surgical procedures and follow-up care will continue to be coordinated through the Subscriber's PCC.

Chapter 7

BlueCard®

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BlueCard Introduction

Overview

The BlueCard Program links health care providers and the independent Blue Cross and Blue Shield plans (Blue plans)* across the country and abroad with a single electronic network for professional, outpatient, inpatient claims processing and reimbursement. The program allows Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Providers in every state to submit claims for Blue Cross Subscribers to their local Blue plan, eliminating the need to track receivables from multiple Blue plans.

Through the BlueCard program, Providers can submit claims directly to Blue Cross for Subscribers who have coverage with a Blue plan other than Blue Cross. Blue Cross will be Providers' contact for medical records submission, claims payment, problem resolution and adjustments.

BlueCard is a national program that enables Blue plan Subscribers to obtain Health Services wherever they are in the United States. The program links participating healthcare providers with all the Blue plans across the nation through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

In addition to Health Services provided to Subscribers enrolled in health benefit plans underwritten or administered by Blue Cross, the Provider Service Agreement applies to Health Services provided to Subscribers enrolled in benefit plans underwritten or administered by other Blue plans approved by the Blue Cross and Blue Shield Association; provided, however, that any Provider that has entered into a separate agreement with another Blue plan operating in a territory adjoining that of Blue Cross shall be entitled to the rights and privileges of that agreement where applicable and provided further, however, that to the extent Health Services are provided by Provider to a Subscriber in Minnesota or in a county of Iowa, North Dakota, South Dakota or Wisconsin, and which county is directly adjacent to Minnesota, the terms and provisions of the Provider Service Agreement shall be applicable to, and control with respect to, such Health Services.

* Each Blue plan is an independent licensee of the Blue Cross and Blue Shield Association.

**Identifying BlueCard®
Subscribers**

BlueCard Subscribers can easily be identified by the three alpha characters preceding their identification (ID) number and the suitcase logos; either empty, or with letters “PPO” inside, on their cards. Although the format of the identification number may vary from Blue plan to Blue plan, Provider can always recognize the trusted Blue Cross and Blue Shield emblems. Providers are encouraged to make a copy of both the front and back of the Subscriber’s ID card. When submitting claims, enter the Subscriber’s ID number exactly as it appears on the card, including the alpha prefix.




Although all Blue plans participate in the BlueCard Program, there are some programs that are exempt such as Medicaid. If the Subscriber is carrying a current Blue Cross ID card and there is no suitcase logo on the card, but there is an alpha prefix, claims should still be filed to Blue Cross as any other claim. Blue Cross will facilitate the processing of that claim on Provider's behalf.

Identifying BlueCard® Subscribers (continued)

Important facts concerning-Subscriber IDs:

- A valid Subscriber ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that Provider may see cards with ID numbers between 6 and 14 numbers/letters following the alpha prefix.
- Do not add/delete characters or numbers within the Subscriber ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue plan.
- Subscribers who are part of the Federal Employee Program will have the letter "R" in front of their Subscriber ID number.

Examples of ID numbers:

ABC1234567	ABC1234H567	ABC12345678901234
		
Alpha Prefix	Alpha Prefix	Alpha Prefix

Providers servicing out-of-area Subscribers, may find the following tips helpful:

- Ask the Subscriber for the most current ID card at every visit. Since new ID cards may be issued to Subscribers throughout the year, this will ensure that the most up to date information is available in the Subscriber's file.
- Verify with the Subscriber that the ID number on the card is not his/her Social Security number. If it is, call the BlueCard eligibility line **1-800-676-BLUE** to verify the ID number.
- Make a copy of the front and back of the Subscriber's ID card and pass this key information on to Provider's billing staff.

NOTE: Subscriber ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the Subscriber ID numbers.

**Identifying BlueCard®
Subscribers
(continued)**

Alpha Prefix

The three-character alpha prefix at the beginning of the Subscriber's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue plan or national account to which the Subscriber belongs. It is critical for confirming a Subscriber's Blue Plan membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, Provider may experience a delay with the claim processing. Do not make up alpha prefixes.

Do not assume that the Subscriber's ID number is the Social Security number. All Blue plans replaced Social Security numbers on Subscriber ID cards with an alternate, unique identifier.

Identifying BlueCard® Subscribers (continued)

Sample Member ID Cards



The "suitcase" logo may appear anywhere on the front of the card.

The three-character alpha prefix.



Definitions

Terms that Provider will hear when dealing with BlueCard Subscribers:

Term	Definition
BlueCard Program	A program that enables Subscribers to obtain Health Services while traveling or living in another licensee's service area and receive the benefits of their Blue Cross Subscriber Contract.

How the Program Works

The BlueCard Program is designed to work as follows:

1. A Subscriber having Blue plan coverage receives services at Provider's office.
2. Provider submits the claim to Blue Cross.
3. Blue Cross will price the claim according to Provider's Provider Service Agreement and send the claim electronically to the Subscriber's Blue plan for benefit determination.
4. The Subscriber's Blue plan applies the Subscriber's benefits and sends the information back to Blue Cross. Blue Cross communicates the outcome of the claim to the Subscriber.
5. Blue Cross will send the *electronic remittance advice* and payment for eligible benefits to Provider.
6. Deductible and coinsurance collection from Subscribers can occur once the claim is adjudicated and Provider receives its *electronic remittance advice (835)* or views its remittance advice on **www.availity.com**.

BlueCard Service

Claims Questions

The site **www.availity.com** should be used to check the status of a BlueCard claim. Enter only the Subscriber's Blue Cross ID number without the alpha prefix and the dates of service.

Claim status is also available by calling provider services. Status is available via a FAX or automated voice response.

Blue Cross encourages Provider to use automated and web-based resources whenever possible. Provider can obtain eligibility, benefits and claim status for Subscribers through its fax-back feature by calling **1-800-262-0820** or **(651) 662-5200**. More detailed information can also be obtained at **www.availity.com**. To register for access to this multi-payer provider portal, please visit the website or call **1-800-AVAILITY**.

Use of these resources for most inquiries ensures that provider services phone staff is available to assist with questions or concerns regarding more complicated benefits, claims and problem resolution.

Please pay special attention to the phone prompts to ensure connection to the correct representative within Blue Cross provider services.

BlueCard claims cannot be viewed on BLUELINE.

Benefits and Eligibility

Providers may contact BlueCard for benefits and eligibility at **1-800-676-BLUE (2583)** for information concerning other Blue plans' Subscribers. If the automated system on the BlueCard eligibility line cannot identify the three digit alpha prefix that is being stated, after the second failed attempt, the caller will automatically be transferred to a BlueCard agent. The BlueCard agent will need one of the following in order to validate:

1. Alpha prefix
2. Plan code
3. Name of Blue plan
4. Employee name
5. State in which the Subscriber's Blue plan is located (can be found on the back of the Subscriber's ID card)

The BlueCard agent will ask for the alpha prefix on the ID card and will then transfer to the subscriber's Blue plan. They will provide the information requested.

Providers may also submit a 270 request via provider web self service for benefits and eligibility information. In addition, Provider can send an electronic request (EDI) via Availity, but must be registered to do so. * Be sure to include:

1. ID number, including alpha prefix
2. Subscriber's full name
3. Date of birth

* Availity registration information: www.availity.com.

BlueCard Preferred Provider Organization (PPO)

The BlueCard PPO program is a national program that offers Subscribers the PPO level of benefits when outside their Blue plan area, allowing them to obtain services from a physician or hospital designated as a PPO provider.

Provider will immediately recognize these PPO Subscribers by the special "PPO in a suitcase" logo on their ID cards.

Blue Cross utilizes the Aware® provider network as its BlueCard PPO network. Subscribers can access information about providers in this network via the toll free number: **1-800-810-BLUE (2583)** or on the BlueCard website, bcbs.com.

Prior Authorization and Admission Notification

Any required prior authorizations and/or admission notifications for Subscribers covered by a Blue plan other than Blue Cross and Blue Shield of Minnesota must go through the Subscriber's home plan. The Provider is expected to contact the Subscriber's Blue plan to request required prior authorizations for these services using the phone number listed on the back of the Subscriber's ID card or by accessing the Medical Policy/Precertification/Prior Authorization Router via Availity or at **providers.bluecrossmn.com**.

The Provider is also responsible for completing required prior authorizations for outpatient services for Subscribers of other Blue plans who receive services outside of their home plan's service area.

The Provider is also responsible for completing admission notifications and prior authorizations for all inpatient admissions and may be liable for charges if notification to the home plan is not completed.

When the length of an inpatient hospital stay extends past the previously approved days, any additional days must also be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials. To avoid delays in the processing of Provider's claims, please assure the necessary approval(s) are obtained in advance of services being rendered.

BlueCard Claims

Claims Submission

Be sure to include the complete alpha prefix and ID number when submitting claims. The alpha prefix should have at least three letters, but may have more, as a portion of the ID number. Provider must submit these claims directly to Blue Cross (see exclusions below). Once Blue Cross processes the claim Provider will receive claims information and any appropriate payment on its *electronic remittance advice (835)*.

Some Subscribers have been issued identification cards with an alpha prefix, but for various reasons the claims cannot process through the BlueCard program. Provider should still submit these claims to Blue Cross, which will forward them to the Subscriber's plan for processing. Blue Cross will notify Provider of this on its weekly *electronic remittance advice (835)*. Even though Provider has been notified that the Subscriber's Blue plan will be processing the Subscriber's claim directly, Provider should still direct all inquiries regarding that claim to Blue Cross. Blue Cross will act as Provider's single point of contact for that claim. See *Claims Processed by the Subscriber's Plan*, later in this chapter.

Submit the claim to Blue Cross when:

- Providing Health Services to a Subscriber from Minnesota, **or**
- Providing Health Services to a Subscriber who has coverage with a Blue plan in another part of the country and Provider is located in Minnesota.

Note: Providers who have Provider Service Agreements with both Blue Cross and another Blue plan should consult with Blue Cross about the handling of non-Minnesota Subscriber claims.

Exclusions

The following are exclusions to the BlueCard program. Please submit these claims as instructed on the ID card:

- Dental services covered under a stand-alone dental contract.
- Drug claims billed by a pharmacy.
- Federal Employee Program (FEP).

Electronic Data Interchange (EDI) Submission

For Electronic Data Interchange submission:

- All BlueCard claims must be sent electronically using the Minnesota Uniform Companion Guide. Refer to Chapter 8, *Claims Filing*, for more information regarding electronic submission of claims.
- Be sure to include the alpha prefix with no spaces between the prefix and the ID number.
- Be sure to send the Subscriber's ID number as it appears on the ID card.
- Be sure to include accurate Subscriber and patient information.
- Be sure to use the correct patient relationship.

Paper Submission

- Effective July 15, 2009, all claims from Minnesota providers must be submitted electronically due to Minnesota Statute - 62J.536. (Provider Quick Points QP7-09). Refer to Chapter 8, *Claims Filing*, for more information regarding claims submission.

Coding

Code claims as the same as for local claims. Refer to Chapter 11, *Coding Policies and Guidelines*, for more coding information.

Medical Records

There are times when the Subscriber's Blue plan will require medical records to review the BlueCard claim. In such cases, Blue Cross will notify Provider. Should Provider receive a request for medical records directly from the Subscriber's Blue plan, forward the requested medical records to Blue Cross. Blue Cross will coordinate with the Subscriber's Blue plan. Always include the Subscriber's Blue plan ID number with the alpha prefix. In accordance with the Provider Service Agreement, Provider shall not bill Blue Cross or the Subscriber for medical records.

Managed Care

It is generally the responsibility of the Subscriber's Blue plan to approve or deny claims. This is also true for managed care reviews. Provider will **not** be responsible, and the Subscriber may be billed as indicated on Provider's remit for the following denials when applicable to a Subscriber with coverage through a Blue plan other than Blue Cross:

- Investigative services
- Care management charges or penalties
- Medical Necessity

Claims Processed by Blue Cross

Claims Notification

Blue Cross will issue claims payment and notification directly to Provider via standard *electronic remittance advice (835)* or by *posting Provider's remittance to www.availity.com*. Statements have been sorted to provide a separate section for BlueCard business for providers billing on the CMS-1500 form or the 837P electronic format. For those providers billing on the CMS-1450 (UB-92) or the 837I electronic format, the claims will not be separated.

Subscribers' *Explanation of Benefits (EOB)* will be issued to them by the Blue plan. Should there be a discrepancy between the Subscriber's EOB and Provider's remittance, please send a copy of both to Blue Cross provider services for review.

Policies

When submitting a BlueCard claim to Blue Cross:

- Providers shall comply with all provisions of the Provider Service Agreement. Subscribers may not be billed as follows, except as otherwise allowed by law:
 - prior to the submission of the claim
 - for any contractual reductions, **or**
 - prior to the finalization of their claims

- Providers will not be responsible for, and Subscriber may be billed, for the following denials by the Subscriber's Blue plan:
 - Investigative services
 - Care management charges or penalties
 - Medical Necessity
 - Non-covered services
 - BlueCard program exempt services (stand-alone dental, drug claims billed by a pharmacy)

Adjustments

Contact Blue Cross if an adjustment is required. Blue Cross does need to work with the Subscriber's Blue plan for adjustments; however, Provider's workflow should not be different. Provider may continue to contact Blue Cross provider services for any questions or status on adjustments for BlueCard claims.

Claims Processed by the Subscriber's Blue Plan

Claims Notification

If the Subscriber's Blue plan is processing the claim because it cannot go through BlueCard processing, Provider will be notified on its weekly *electronic remittance advice (835)*.

The claim will be documented and the remark message will read, "*This claim has been forwarded to the subscriber's home plan for processing.*" Contact Blue Cross for any information regarding this claim, and Blue Cross will contact the Subscriber's Blue plan. Provider may bill the Subscriber for these services.

Policies

Since this is not a BlueCard eligible claim, the Blue Cross Provider Service Agreement generally does not apply.

Adjustments

Communicate adjustment requests to Blue Cross, which will contact the Subscriber's Blue plan on Provider's behalf.

Appeals

Please refer to Chapter 10 for information regarding appeals.

Medical Records

Overview

Medical Records

Blue plans around the country have made improvements to the medical records process to make it more efficient. Blue Cross is now able to send and receive medical records electronically with other Blue plans. This new method significantly reduces the time it takes to transmit supporting documentation for out of area claims, reduces the need to request records multiple times and eliminates lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area subscribers?

1. As part of the pre-authorization process—If Provider receives requests for medical records from other Blue plans *prior to rendering Health Services*, as part of the pre-authorization process, Provider will be instructed to submit the records directly to the Subscriber's Blue plan that requested them. This is the only circumstance where Provider would not submit them to Blue Cross.
2. As part of *claim review and adjudication*—These requests will come from Blue Cross in a form of a letter requesting specific medical records and including instructions for submission.

BlueCard medical record process for claim review

1. An initial communication, generally in the form of a letter, should be received by Provider's office requesting the needed information.
2. A remittance may be received by Provider's office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records Provider submits might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is **not** a duplicate request for medical records. If Provider submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Blue Cross to ensure the original submission was received and processed. This will prevent duplicate records being sent unnecessarily.

Overview (continued)

3. If Provider received only a remittance advice indicating records are needed, but Provider did not receive a medical records request letter, contact Blue Cross to determine if the records are needed from Provider's office.
4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful ways Provider can assist in timely processing of medical records

1. If the records are requested following submission of the claim, forward all requested medical records to Blue Cross.
2. Follow the submission instructions given on the request, using the specified address or FAX number. The address or FAX number for medical records may be different than the address used to submit claims.
3. Include the cover letter Provider received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Cross.
4. Please submit the information to Blue Cross as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Coordination of Benefits (COB) Claims

Guidelines

Coordination of benefits (COB) refers to how Blue Cross ensures Subscribers receive full benefits and prevents double payment for Health Services when a subscriber has coverage from two or more sources. The Subscriber's Contract explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Provider agrees to make a good faith effort to secure information on the sources of third party coverage available to each Subscriber and forward such information to Blue Cross or the plan sponsor. Provider agrees to coordinate benefits with other payers in accordance with Blue Cross' or the Plan Sponsor's procedures, and to submit copies of all applicable claims including the applicable payment information received on previous payers remittances to Blue Cross or the Plan Sponsor. Blue Cross or the Plan Sponsor shall use its best efforts to coordinate Health Services due a Subscriber in accordance with the provisions of the Subscriber Contract, and to exercise any subrogation in regard to Health Services provided to Subscriber. Provider shall provide any reasonably requested assistance to this effort. Blue Cross or the Plan Sponsor will administer coordination of benefits consistent with applicable law. When Blue Cross or the Plan Sponsor is the secondary payer, Blue Cross shall make payment according to the terms of the Subscriber Contract, except that payment by Blue Cross shall not exceed the amount that Blue Cross would make if it had Primary Coverage Responsibility. If Medicare is primary, Blue Cross shall coordinate benefits according to the coordination of benefits provisions of the Subscriber Contract.

If Provider discovers the Subscriber is covered by more than one health plan, **and:**

- Blue Cross or any other Blue plan is the primary payer, submit other carrier's name and address with the claim to Blue Cross. If Provider does not include the COB information with the claim, the Subscriber's Blue plan will have to investigate the claim. This investigation could delay Provider's payment or result in a post-payment adjustment, which will increase Provider's volume of bookkeeping.
- Other non-Blue plan is primary and Blue Cross or any other Blue plan is secondary, submit the claim to Blue Cross only after receiving payment from the primary payer, including the explanation of payment

**Guidelines
(continued)**

from the primary carrier. If Provider does not include the COB information with the claim, the Subscriber's Blue plan will have to investigate the claim. This investigation could delay Provider's payment or result in a post-payment adjustment, which will increase Provider's volume of bookkeeping.

Coordination of Benefits Questionnaire

To streamline Blue Cross' claims processing and reduce the number of denials related to coordination of benefits, a COB questionnaire is now available to Provider at **providers.bluecrossmn.com** that will help Provider and Provider's Subscribers avoid potential claim issues. The COB form is in the "Other Forms" section in the Forms and Publications area.

When Provider provides Health Services to any Blue Plan Subscribers and is aware that Subscriber might have other health insurance coverage (e.g. Medicare), give a copy of the questionnaire to the Subscriber during their visit. Ask the Subscriber to complete the form and send it to the Subscriber's Blue plan as soon as possible. Subscribers will find the address on the back of their member identification card or by calling the customer service numbers listed on the back of the ID card. Collecting COB information from Subscribers before filing a claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

Claim Payment

Guidelines

- If Provider has not received payment for a claim, do not resubmit the claim; it will be denied as a duplicate. This also causes Subscriber confusion because of multiple Explanations of Benefits (EOBs). Blue Cross' standard time for claims processing is 17 days. However, claim processing times at various Blue plans vary.
- If Provider does not receive payment or a response regarding payment, please call Blue Cross provider services at **(651) 662-5200** or **1-800-262-0820** or visit www.availity.com to check the status of the claim.
- In some cases, a Subscriber's Blue plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from Provider, Blue Cross may either ask Providers for the information or give the Subscriber's Blue plan permission to contact Provider directly.

Claim Status Inquiry

Overview

Blue Cross of Minnesota is Provider's single point of contact for all claim inquiries.

Claim status inquiries can be done by:

- Phone—call provider service at **(651) 662-5200** or **1-800-262-0820**.
- Electronically—send a HIPAA transaction 276 (claim status inquiry) to Blue Cross via EDI.

Calls from Subscribers and Others with Claim Questions

Overview

If Subscribers contact Provider, advise them to contact their Blue plan and refer them to their ID card for a customer service number.

The Subscriber's Blue plan should not contact Provider directly regarding claims issues, but if the Subscriber's Blue plan contacts Provider and asks Provider to submit the claim to them, refer them to Blue Cross.

Traditional Medicare-Related Claims

Guidelines

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payer, submit claims to Provider's local Medicare intermediary.
- As of January 1, 2008, all Blue plan claims are set up to automatically crossover to the Subscriber's Blue plan after being adjudicated by the Medicare intermediary.

How do I submit Medicare primary / Blue plan secondary claims?

- For Subscribers with Medicare primary coverage and Blue plan secondary coverage, submit claims to the Provider's Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that the Provider enters the correct Blue plan name as the secondary carrier. This may be different from the local Blue plan. Check the Subscriber's ID card for additional verification.
- Include the alpha prefix as part of the Subscriber identification number. The Subscriber's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership, coverage and key to facilitating prompt payments.

When receiving remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on the Provider's behalf to the appropriate Blue plan and the claim is in process. There is no need to resubmit that claim to Blue.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue Cross with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on the claim.
- For claim status inquiries, contact Blue Cross through **www.availity.com**

Guidelines (continued) When should I expect to receive payment?

Claims submitted to the Medicare intermediary will be crossed over to the Blue plan only after they have been processed. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue plan for processing about the same time Provider receives the Medicare remittance advice. As a result, it may take additional 14-30 business days for Provider to receive payment from the Blue plan.

What should I do in the meantime?

If Provider submitted the claim to the Medicare intermediary/carrier, and hasn't received a response to its initial claim submission, don't automatically submit another claim. Rather, Provider should:

- Review the automated resubmission cycle on its claim system.
- Wait 30 days.
- Check claims status before resubmitting.

Sending another claim, or having a billing agency resubmit claims automatically, slows down the claim payment process and creates confusion for the Subscriber.

Who do I contact if I have questions or to check claim status?

If Provider has questions, please contact Blue Cross through www.availity.com.

Medicare Advantage Claims through BlueCard

Overview

“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (for example, enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Types of Medicare Advantage Plans**Medicare Advantage HMO**

A Medicare Advantage HMO is a Medicare managed care option in which Subscribers typically receive a set of predetermined and prepaid services provided by a network of Health Care Practitioners and hospitals. Generally (except in urgent or emergency care situations), Health Services are only covered when provided by in network providers. The level of benefits and the coverage rules may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows Subscribers to determine—at the point of service—whether they want to receive certain designated Health Services within the HMO system, or seek such Health Services outside the HMO’s provider network (usually at greater cost to the Subscriber). The Medicare Advantage POS plan may specify which Health Services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows Subscribers who enroll access to Health Services provided outside the contracted network of providers. Required Subscriber cost-sharing may be greater when covered Health Services are obtained out of network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the Subscriber may go to any Medicare approved Health Care Practitioner or hospital that accepts the plan’s terms and conditions of participation. Acceptance is “deemed” to occur where the provider is aware, in advance of furnishing services, that the Subscriber is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays Health Care Practitioners and providers on a fee-for-services basis for services rendered to such Subscribers. Subscribers are responsible for cost-sharing, as specified in the plan.

Types of Medicare Advantage Plans (continued)

Medicare Advantage PFFS varies from the other Blue products Provider might currently participate in:

- Provider can see and treat any Medicare Advantage PFFS Subscriber without having a Provider Service Agreement with Blue Cross.
- If Provider does provide Health Services, Provider will do so under the terms and conditions of that Subscriber's Blue plan.
- Please refer to the back of the Subscriber's ID card for information on accessing the plan's terms and conditions. Provider may choose to render Health Services to a MA PFFS Subscriber on an episode of care (claim-by-claim) basis.
- MA PFFS terms and conditions may vary for each Blue plan and Provider is advised to review them before servicing MA PFFS Subscribers.
- Submit MA PFFS claims to Blue Cross.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible; The other part is a special savings account where Medicare deposits money to help Subscribers pay their medical bills.

Eligibility Verification

- Verify eligibility by contacting **1-800-676-BLUE (2583)** and providing an alpha prefix or by submitting an electronic inquiry to **www.availity.com** and providing the alpha prefix.
- If Provider experiences difficulty obtaining eligibility information, please record the alpha prefix and report it to Blue Cross.

**Medicare Advantage
Claims Submission**

- Submit all Medicare Advantage claims to Blue Cross.
 - Do not bill Medicare directly for any Health Services rendered to a Medicare Advantage Subscriber.
 - Payment will be made directly by a Blue.
-

**Reimbursement for
Medicare Advantage
PPO, HMO, POS**

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if Provider accepts Medicare assignment and renders Health Services to a Medicare Advantage Subscriber for whom is no obligation to provide services under Provider's Provider Service Agreement with a Blue plan, Provider will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount Provider would collect if the beneficiary were enrolled in traditional Medicare).

MedicareBlue PPO and Group MedicareBlue PPO are regional Medicare Advantage plans with a Medicare contract.

MedicareBlue PPO and Group MedicareBlue PPO coverage is separately issued by one of the following plans:

- Wellmark Blue Cross Blue Shield of Iowa
- Blue Cross Blue Shield of Minnesota
- Blue Cross Blue Shield of Montana
- Blue Cross Blue Shield of Nebraska
- Blue Cross Blue Shield of North Dakota
- Wellmark Blue Cross Blue Shield of South Dakota
- Blue Cross Blue Shield of Wyoming.

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan or its branded member's affiliate. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amount from the Subscriber at the time of service, and may not otherwise charge or balance bill the Subscriber.

Note: Subscriber payment responsibilities can include more than copayments (e.g., deductibles).

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

**Reimbursement for
Medicare Advantage
PPO, HMO, POS
(continued)****Services for local and regional Medicare Advantage
Subscribers**

Situation below is where Provider has a Provider Service Agreement with Blue Cross for MA and provides Health Services to a Blue Cross MA Subscriber.

If Provider accepts Medicare assignment and renders Health Services to a local or regional Medicare Advantage Subscriber for whom Provider has an obligation to provide services under its Provider Service Agreement with a Blue plan, Provider will be considered a contracted Provider and be reimbursed per the Provider Service Agreement.

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amounts from the Subscriber at the time of service, and may not otherwise charge or balance bill the Subscriber.

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual plan contractual arrangements.

Services for out-of-area Medicare Advantage Subscribers

Situation below is where Provider has a Provider Service Agreement with Blue Cross for local and regional MA and provides Health Services for out-of-area MA Subscribers.

If Provider accepts Medicare assignment, has a Blue plan Provider Service Agreement to provide Health Services for local and regional Medicare Advantage Subscribers only, and renders Health Services to out-of-area Medicare Advantage Subscribers, Provider will be reimbursed at the Medicare allowed amount (i.e., the amount Provider would collect if the Subscriber were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual plan contractual arrangements.

Reimbursement for Medicare Advantage PPO, HMO, POS (continued)

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amounts from the Subscriber at the time of service and may not otherwise charge or balance bill the Subscriber.

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Reimbursement for Medicare Advantage Private-Fee-for-Service (PFFS)

Health Services for out-of-area Medicare Advantage PFFS Subscribers

Situation below is where Provider renders Health Services for out-of-area MA PFFS-Subscribers.

If Provider has rendered Health Services for an out-of-area Medicare Advantage PFFS Subscriber but is not obligated to provide services to such Subscriber under a provider service agreement with a Blue plan, Provider will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount Provider would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable Subscriber cost-sharing amounts, reimbursement is made directly by a Blue plan. In general, Provider may collect only the applicable cost-sharing (e.g., copayment or coinsurance) amounts from the Subscriber at the time of service and may not otherwise charge or balance bill the Subscriber.

Please review the remittance notice concerning Medicare Advantage plan payment, Subscriber's payment responsibility and balance billing limitations.

Chapter 8

Claims Filing

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Administrative Simplification

Introduction

Minnesota Statute 62J.536 requires health care providers and group purchasers (payers, Health Plans) to exchange eligibility requests, claims and remittances electronically using standard formats. The intent of the law is to reduce costs, simplify and speed up health care transactions, and to give providers and Health Plans one set of rules to follow for electronic transactions. This statute applies to all health care providers in Minnesota, regardless of participating status.

Web-based Claim Submission, Eligibility and Remittance Tool

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) offers a no-cost, web-based tool through Availity to comply with Minnesota Statute 62J.536. Availity, an independent company, also provides no-cost solutions to obtain eligibility and benefits as well as allows Provider to view its remittance information. Availity, an independent company, is a one stop shop that optimizes information exchange between multiple health care stakeholders through a single secure network. Provider may also take advantage of a range of optional, value-added services for a nominal cost. For more information contact Availity at **availity.com** to register for its no-cost web-based tools.

Pharmacy and Dental Claims

The requirement to submit all claims electronically includes dental and pharmacy formatted claim types.

Dental Providers should submit 837D transactions through Availity. For more information regarding electronic claim submission and to register, contact Availity at www.availity.com.

Medical Pharmacy and MTM: The requirement to submit all claims electronically will include pharmacy formatted claims.

Pre-system Edits

Blue Cross has aligned its pre-system edits with the rules published in the Uniform Claims Companion Guides found on the Administrative Uniformity Committee (AUC) website at:

[Home - MN Dept. of Health \(state.mn.us\)](http://state.mn.us)

Claims with Attachments

Blue Cross accepts claims with attachments electronically. The claim must adhere to the electronic rules found in the Uniform Companion Guides and include the appropriate populated data as indicated in section 4.2.3.4 of the guides. The related attachment may be faxed to Blue Cross at **1-800-793-6928** or mailed to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164-0338

The attachment cover sheet found on the AUC website must be used as the first page on each claim attachment. Instructions for completing the attachment cover sheet are also available on the AUC website.

Blue Cross has compiled a list of questions and answers in response to providers' inquiries regarding sending attachments on electronic claim transactions.

Questions and Answers

1. My clinic has a policy of covering all documentation with an internal cover sheet to protect PHI. Should I be covering the attachments I am sending with this cover sheet?

No. Per the AUC Guidelines the only acceptable cover sheet for attachments is the AUC Uniform COVER SHEET For Health Care Claim Attachments. This form can be modified to include a PHI message on the bottom of the page if the provider desires but is the ONLY acceptable cover sheet when sending attachments.

Claims with Attachments (continued)**2. Can I send appeals, adjustment requests, status checks and general correspondence using the AUC Uniform COVER SHEET For Health Care Claim Attachments?**

No. The AUC Uniform COVER SHEET For Health Care Claim Attachments is ONLY for use when submitting attachments for first time claims that have been sent electronically. It is not to be used for appeals, adjustment requests, status checks or general correspondence. There are separate forms and fax numbers for these types of correspondence. Please use the appropriate cover sheet for each type of correspondence. Below is a list of the forms and fax numbers for each type of correspondence:

- AUC Uniform COVER SHEET For Health Care Claim Attachments: **1-800-793-6928** (use for attachment to original claims only)
- AUC Appeal Request Form: **(651) 662-2745** (use to submit claim appeals via fax)

How do I reach Provider Services?

- Local telephone **(651) 662-5200**
- Toll-free telephone **1-800-662-2745** (BlueCard members **1-800-676-2853**)
- Messaging through Availity Essentials
- If instructed to send a fax by your Provider Services representative, include a cover sheet and send to **(651) 662-2745**.
- For further reference on the submission of attachments, please visit the AUC website:

[Home - MN Dept. of Health \(state.mn.us\)](http://state.mn.us)

3. Can I change or remove the AUC Logo on the AUC Uniform COVER SHEET For Health Care Claim Attachments?

No. Blue Cross' automated intake process looks for the AUC Logo when preparing to scan the attachment. If the LOGO is missing or has been changed, the automated process cannot take place. This causes delays in the imaging of the document and ultimately can lead to delays in the processing and payment of the claim. This is another reason why providers must not use an internal cover sheet. Providers must also fax attachments head-up or top of the page first as the recognition software only scans the top third of the page for the LOGO.

Claims with Attachments (continued)

- 4. If I have the Other Insurance Carrier payment information in the 837 electronic claim transaction, do I also have to send the EOB in an attachment or notify Blue Cross that it is in my office?**

No. Per the AUC Guidelines, submit the Other Insurance Carrier payment information within the 837. HIPAA regulations forbid populating the claim record with Other Insurance Carrier information and sending the same information in an attachment. They further forbid sending data in an attachment that can be codified within the claim record.

- 5. Can I send the attachment before I send the 837 claim transaction?**

Yes, provided the provider completes the PWK segment on the 837 with the appropriate information from the AUC Uniform COVER SHEET For Health Care Claim Attachments. The PWK segment must include the Report Type code, Report Transmission Code and the Transaction Control Number (the Attachment Control Number on the AUC Uniform COVER SHEET For Health Care Claim Attachments). Failure to include this information on the 837 will cause delays in processing and payment and may result in a denial of the claim.

**Claims with
Coordination of
Benefits**

Blue Cross accepts electronic claims with previous payer payment information populated per the requirements in the Minnesota Uniform Companion Guides. For proper adjudication claims must contain all previous payer group codes, and ANSI Claim Adjustment Reason Codes as they were received from the previous payer. These claims do not require an attachment when populated within the claim record. Refer to the Minnesota Uniform Companion Guides, section 4.2.3.5 for more information.

Provider agrees to make a good faith effort to secure information on the sources of third party coverage available to each Subscriber and forward such information to Blue Cross or the Plan Sponsor. Provider agrees to coordinate benefits with other payers in accordance with Blue Cross' or the Plan Sponsor's procedures, and to submit copies of all applicable claims including the applicable payment information received on previous payers remittances to Blue Cross or the Plan Sponsor. Blue Cross or the Plan Sponsor shall use its best efforts to coordinate Health Services due a Subscriber in accordance with the provisions of the Subscriber Contract, and to exercise any subrogation in regard to Health Services provided to Subscriber. Provider shall provide any reasonably requested assistance to this effort. Blue Cross or the Plan Sponsor will administer coordination of benefits consistent with applicable law. When Blue Cross or the Plan Sponsor is the secondary payer, Blue Cross shall make payment according to the terms of the Subscriber Contract, except that payment by Blue Cross shall not exceed the amount that Blue Cross would make if it had Primary Coverage Responsibility. If Medicare is primary, Blue Cross shall coordinate benefits according to the coordination of benefits provisions of the Subscriber Contract.

Blue Cross has compiled a list of questions and answers in response to providers' inquiries regarding the electronic submission of Coordination of Benefits information.

**Claims with
Coordination of
Benefits (continued)****Questions and Answers**

- 1. I understand that there is information on the HIPAA 835 transaction that I have to include on the electronic 837 COB transaction. Can you tell me what I have to include so I can make sure I get paid accurately?**

It is important to use the Minnesota Uniform Companion Guides along with the HIPAA Implementation Guides to ensure the correct segments and elements are completed. The 2320, 2330A, 2330B, and the 2430 loops carry a good portion of the COB information a payer needs to process a secondary claim.

The HIPAA 835 transaction provides most of the necessary information to complete the appropriate segments and elements.

The HIPAA 835 transaction from the prior payer(s) should provide the CAS segments (loops 2100 and/or 2110), CLP segment (loop 2100), and the SVC segment (loop 2110), which are used to complete the 837 COB transaction.

- 2. I understand the CAS segment is important for the correct processing of my COB 837 transaction. Where do I get the CAS segment information from?**

Again, the CAS segment information on the 837 COB transactions should come directly from the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. This information must never be altered or combined in any manner.

- 3. Do I need to do any combining of Claim Adjustment Reason Codes or change them to specific codes a Supplemental Insurer might want?**

No, when completing the COB information on the 837 use the information as it was provided on the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. Never change or alter any of the prior payer(s) payment information including the Claim Adjustment Reason Codes (CARC) and Claim Adjustment Group Codes. Changing codes is a violation of HIPAA and could result in payment errors or processing delays. Per the HIPAA Implementation Guide, "Codes and associated amounts should come from 835s (Remittance Advice) received on the claim." Payers utilize the codes to adjudicate based on the information sent.

**Claims with
Coordination of
Benefits (continued)**

- 4. I know there are Medicare primary claims that should have crossed over and Medicare has had some problems lately with not being able to cross claims over to supplemental payers. Should I send all my Medicare Primary COB claims just in case?**

No, “automatic” rebilling often results in duplicate claims, increases administrative costs, and delays processing. Please refer to *Medicare Primary COB Claim* section later in this chapter.

If the claim is not showing as crossed over on provider web self-service after 30 days from the date the provider received its Medicare payment, then the provider may submit the claim electronically populating the claim record with the COB information exactly as it was received on the Medicare ERA.

- 5. I have situations where my Medicare primary claims have been adjusted and Medicare is now paying on claims they have denied. How do I send these COB claims to my supplemental insurer?**

These claims are COB adjustments to the original claim and should crossover to Blue Cross directly from Medicare. Again, please refer to *Medicare Primary COB Claim* section later in this chapter.

If the adjustment did not crossover as it should have within 30 days after the provider received the updated Medicare ERA, submit an adjustment/replacement claim.

- 6. I have a claim where Medicare paid first. They have now decided to pay one of the services on my three line claim. Should I just send in the COB claim for that one line for Blue Cross to pay the coinsurance and deductible?**

No, never send a partial claim. This would be a violation of the rules in the Minnesota Uniform Companion Guides. Again, this could result in duplicate claims, increased administrative costs, and processing delays. If the prior payer has made a change to the original or prior claim processing outcome, the original or prior claim must be adjusted to ensure the secondary payment is correct. A “partial” claim should never be sent regardless of whether it is an original or adjustment. As noted in response to question #3 above, if the prior payer has adjudicated a claim with three services lines, all three service lines should be sent to the secondary payer. Never alter the charges and critical claim information when sending it to a secondary/tertiary payer for payment consideration.

**Claims with
Coordination of
Benefits (continued)**

7. I have talked with other providers and they tell me that a COB claim must balance. What must balance?

The claim paid amounts must be equal to or greater than the line level paid amounts. The CAS segments must always reflect exactly what the prior payer has indicated on HIPAA 835 transaction or Remittance Advice/Explanation of Benefits. Do not add or combine the CAS information. Typically, the professional claim allowed and paid amounts should not be greater than the billed amounts.

More information regarding balancing is available at:

X12.org

- Products
- Learn More
- Technical Reports
- Implementation Guide – Type (TR3)

8. When the prior payer is Medicare how do I list them as the primary payer? Do I list them by the Medicare Office, CMS, Federal Medicare, the name of the Medicare contractor, etc?

When Medicare is the prior payer, Blue Cross suggests listing the prior payer as “Medicare.”

9. I am sending COB in the 837 transaction and also sending the EOB as an attachment with the report type code EB and report transmission code AA. This is to make sure that you get the COB information.

In these situations, the Report of Transmission (PWK02) is AA indicating the EOB is available upon request at the provider office. The HIPAA 837 Implementation Guides, Report of Transmission (PWK Segment), states “The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope.” Therefore, sending the information within the transaction and also sending the PWK would be non-compliant and may result in a rejection.

**Medicare/Uniform
Companion Guide
Coding Alignment**

Blue Cross has made several system modifications to accept claims coded using the rules indicated by either Medicare or the Minnesota Uniform Companion Guides, Appendix A. Provider must code its claims to meet the specifications set forth in the Minnesota Uniform Companion Guides. Although claims must be standardly submitted, charges may not be covered due to Subscriber benefits or Blue Cross payment policy.

Questions

Questions regarding the content of the 277CA Claim Acknowledgement should be directed to provider services at **(651) 662-5200** or **1-800-262-0820**.

Questions regarding the payer electronic reports not being received should be directed to Provider's clearinghouse. If Provider's clearinghouse is Availity, please refer to their website at availability.com.

For questions regarding the attachment requirements, attachment cover sheet and related instructions, Coordination of Benefits or coding requirements, refer to the AUC website at:

[Home - MN Dept. of Health \(state.mn.us\)](http://state.mn.us)

1500 HCFA Form

Professional Claim Submission

The paper 1500 Health Insurance Claim Form (HCFA) (also referred to as the CMS 1500) is accepted only from out-of-state nonparticipating providers per Minnesota Statute 62J.536 and the Provider Service Agreement.

The electronic transaction 837P is the only accepted claim submission format for professional claims.

1500 HCFA Manual

The National Uniform Claim Committee (NUCC) has a reference instruction manual detailing how to complete the 1500 HCFA form. The purpose of this manual is to help standardize nationally the manner in which the form is being completed. A copy of the instruction manual is available on the NUCC website - nucc.org/.

About the NUCC

The National Uniform Claim Committee is a voluntary organization whose members include representatives from major provider, payer, health researchers, and other organizations representing billing professionals, and electronic standard developers.

The NUCC maintains the uniform data set known as the National Uniform Claim Committee Data Set designed for the non-institutional claims. The NUCC is also a signatory to a Memorandum of Understanding with five other organizations designated by the U.S. Department of Health and Human Services to collectively serve as the Designated Standard Maintenance Organizations (DSMO) to the HIPAA Transaction Standard Implementation Guides.

UB-04 (CMS 1450) Form

Institutional Claim Submission

The paper UB-04 (also referred to as the CMS-1450) is accepted only from out-of-state nonparticipating providers per Minnesota Statute 62J.536 and the Provider Service Agreement.

The electronic transaction 837I is the only accepted claim submission format for institutional claims.

Provider and Blue Cross agree to abide by the provisions of the Aware Provider Service Agreement to the extent applicable when the Provider bills Blue Cross for Health Services provided by a Health Care Professional. Provider further agrees that such Aware Provider Service Agreement will apply whenever Providers are required by Blue Cross to bill for their Health Services separately. The preceding sentence shall not apply to Health Services provided by hospital-based physicians who bill Blue Cross separately for such Health Services. Payment for professional Health Services shall be made according to the then-current applicable fee schedule as set forth in the Aware Provider Service Agreement based on Provider's primary specialty code assigned by Blue Cross. Effective July 1 of each year, Blue Cross implements the most current Relative Value Units (RVUs) as published in the Federal Register and as implemented by Blue Cross. Payment for Health Services not assigned RVUs shall be calculated at the then current applicable fee schedule as set forth in the Aware Provider Service Agreement. Participating Providers may request a list of applicable rate allowances by submitting an e-mail request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Cross Internal Reference Number(s).

UB-04 Manual

The National Uniform Billing Committee (NUBC) publishes a manual containing the claim data specifications that are submitted on the 837I or UB-04 claim format and guidelines on completion of the UB-04 form.

About the NUBC

Established in 1975, the NUBC is the official data content body responsible for maintaining the data set for institutional health care providers. Representation includes provider, payer, electronic standards development organizations, public health data standards organizations, and others. The NUBC is also one of six Designated Standard Maintenance Organizations (DSMO) responsible for the maintenance and development of HIPAA administrative simplification transaction standards.

Note: Also see http://www.nubc.org/INFORMATION_ON_UB-04.pdf

Ordering Forms and Manuals

HCPCS, CPT, ICD 9 CM, ICD-10-CM and ICD-10-PCS Manuals	HCPCS, CPT, ICD-9-CM, ICD-10-CM and ICD-10-PCS manuals can be purchased from major bookstores or publishers, such as the American Medical Association.
Technical Reports	<p>X12 produces technical reports with a goal of facilitating consistent implementations of its work.</p> <p>In order to view many of the X12's implementation guides, Visit their website at:</p> <p>Technical Reports X12</p>
Minnesota Uniform Companion Guides	<p>Minnesota Uniform Companion Guides containing instructions for electronic transactions are available free of charge on the AUC website under "MN Uninform Companion Guides" at:</p> <p>Home - MN Dept. of Health (state.mn.us)</p>
1500 HICF (CMS-1500) UB-04 (CMS-1450) Forms	<p>To order 1500 HICFA and UB-04 forms contact:</p> <p>U.S. Government Printing Office (202) 512-0455 or visit the website at: cms.hhs.gov/CMSForms/</p> <p>Provider may also contact form vendors or publishers, such as the American Medical Association or the American Hospital Association.</p>
UB-04 Manual	<p>To order the UB-04 Manual contact:</p> <p>National Uniform Billing Committee (NUBC) at nubc.org/become.html for more information and an order form, or call the American Hospital Association at (312) 422-3390 for questions.</p>
1500 HICF Manual	<p>The National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual is available at nucc.org/</p>

Professional/837P Billing

Zero Billed Charges

Blue Cross will allow zero-billing or no charge submission lines on claims.

Linking and Sequencing

It is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item. Adjudication is based on the first linked diagnosis.

Linking/sequencing rules:

- Sequence numbers relate to the ICD-9-CM and ICD-10-CM diagnosis codes as 1, 2, 3 and 4.
- The primary diagnosis is listed first in the sequence if more than one diagnosis is related.

Place of Service Codes

Only nationally assigned place of service codes are accepted. These codes are available at the following web address:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Site of Service

Blue Cross is specifying, for clarity, the difference between a facility and a non-facility with respect to the place of service where a Health Service was rendered. For billing purposes, professional (837P) billers should use an appropriate place of service code to indicate where Health Services were rendered. Examples of facilities include hospitals and ambulatory surgery centers. Examples of non-facilities include a provider's office and all places not listed below.

The following is a current comprehensive list of facilities, as defined by Blue Cross:

Place of Service Code	Place of Service Name
02	Telehealth Provided Other Than in Patient's Home
05	Indian Health Service Freestanding Facility
07	Tribal 638 Freestanding Facility
13	Assisted Living Facility
18	Place of Employment/Worksite
19	Off-Campus Outpatient Hospital

**Site of Service
(continued)**

Place of Service Code	Place of Service Name
21	Inpatient Hospital
22	On-Campus Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58	Non-Residential Opioid Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
99	Other Place of Service

Community Mental Health Center

Place of service 53 is defined as a Community Mental Health Center, which per the Centers for Medicare & Medicaid Services (CMS) is “a facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.”

It is expected that when a professional claim is submitted with place of service 53, that a facility claim will also be submitted for the same services. If a facility claim will not be submitted in addition to the professional claim, a non-facility place of service (for example, Office - place of service 11) would be expected on the professional claim.

Freestanding Ambulatory Surgery Centers

In order to streamline its administrative processes and comply with regulatory requirements, Blue Cross contracts with Freestanding Ambulatory Surgery Centers as professional submitters and requires the following guidelines and provisions:

- **Use of Professional Claims Submission Formats** – Freestanding Ambulatory Surgery Center providers submit claims utilizing a HIPAA 837P claims transaction, in compliance with Minnesota Statute 62J.52. Use national place of service code 24.
- **Adjudication of Services at the Claim Line Level** – Payment is calculated at the lesser of 100% of Provider’s Regular Billed Charges or the Blue Cross fee schedule allowance, implemented at a claim line/service level.
- **Payment of Individual Procedures** – Payment methodologies determine which Health Services are included/excluded from reimbursement, including implants/devices and tissue. Professional services, including anesthesia, should not be billed under the Agreement. Individual provider NPI numbers are not required.
- **Corneal tissue** – Claims that contain charges for corneal tissue using HCPCS code V2785 must be submitted with an invoice for the corneal tissue. Reimbursement will be made to the ASC at the invoice amount.

Freestanding Ambulatory Surgery Centers (continued)

- **Multiple Services Discounting** – Means a reduction in payment rate for multiple significant procedures, tests or therapies performed on the same day, bilateral procedures and terminated procedures.
- **99199** – The code 99199 (unlisted special service, procedure or report) will not be considered for separate reimbursement when submitted by an ASC. 99199 will be denied as provider liability. No additional reimbursement will be considered on appeal.

Applicable to providers on EAPG methodology only:

- **EAPG Ancillary Packaging** – Means lower level ancillary services are packaged and not considered for additional reimbursement.
- **EAPG Base Rate** – Means the dollar rate per Relative Weight of One (1.0).

K3 Segment Usage Instructions for Condition Codes

Condition Code

The NUBC has added condition codes to their code set to identify situations where Workers' Compensation requires duplicate or appeal submissions. The 837P format does not include a standardized way of reporting condition codes. To report applicable condition codes on a professional claim, the K3 segment should be used.

BG is the qualifier to indicate this value and should be followed by the appropriate condition code (refer to the NUBC Guide and Code Set available from the National Uniform Billing Committee at nubc.org).

Report at 2300 loop only.

Institution (837I)/Facility Billing

Claim Format Regulations

HIPAA Administrative Simplification code and transaction regulations dictate the standard claim format and codes for electronically submitted claims. Institutional claims are billed on the 837I electronic format. The paper equivalent is the UB-04 claim form.

Blue Cross considers the following providers as institutional and as such, should bill on the institutional claim format (837I).

Category	Definition
Home health agency	HHA is a public agency or private organization that is primarily engaged in providing skilled nursing services and other therapeutic Health Services, such as physical therapy, occupational therapy, medical social services and home health aide services. Home health agencies can be freestanding or hospital attached. Care is rendered in the home and is in lieu of hospital confinement.
Hospice	Hospice programs provide health care for terminally ill patients. Care may be done in the patient's home, at special hospice units, or a separate hospice care facility.
Hospital	An institution that provides medical, diagnostic and surgical care. Health Services can be rendered on an inpatient or outpatient basis.
Non-residential treatment center	This type of institution is the same as a residential primary treatment center with the exception that Health Services are rendered on an outpatient basis only.
Nursing home	A Skilled Nursing Facility provides skilled nursing care and related Health Services for patients who require medical or nursing care; or rehabilitation services for injured, disabled or sick people.

Claim Format Regulations (continued)

Category	Definition
Psychiatric hospital	A psychiatric hospital provides care to emotionally ill patients. These facilities must be licensed by the state in which they are located.
Residential primary treatment center (IP chem dep)	Residential treatment programs for chemical dependency are planned and purposeful sets of conditions and events for the care of inebriated and drug dependent persons which provides care and treatment for five or more inebriate or drug dependent persons on a 24-hour basis. Excluded for this definition are receiving (detoxification) centers.

Procedure Code Regulations

The medical procedure code set for inpatient services is ICD-9-CM or ICD-10-PCS procedure codes. Procedure information will be reported on outpatient claims using HCPCS codes.

Revenue Codes (FL 42)

A revenue code identifies a specific accommodation and/or ancillary service or billing calculation. A revenue code is four characters. The first digit is usually a 0 (zero); however, there are codes that begin with numbers other than 0 (100X, 210X, 310X). It is important to report all four digits.

HCPCS/ Accommodation Rates/HIPPS Rate Codes (FL 44)

For inpatient bills, the accommodation rate relating to the room and board revenue code is entered.

For outpatient bills, report the HCPCS code, if applicable, to indicate the specific outpatient service. Some HCPCS codes or billing situations may require submission of modifiers. Modifiers are reported following the HCPCS code. Blue Cross accepts all valid modifiers. Although Blue Cross currently does not automatically adjudicate the claim/service based on modifiers, it is still important to submit all modifiers, if applicable.

Duplicate Billing

Blue Cross will only reimburse the professional or clinic Health Services when a Subscriber is seen in a clinic setting (POS 11). Facilities that have clinics physically located onsite or next to a hospital frequently bill an additional claim either electronically or on an 837I with a place of service 22 for the same Health Service that the physician is billing. In some cases, facilities submit revenue code 0361. Blue Cross considers this practice duplicate billing. Facility overhead is included in the professional reimbursement weighting and conversion factor; therefore, complete and final reimbursement will be made on the professional claim only.

Observation Room

Observation Care, billed under revenue code 0762, normally does not extend beyond 24 hours. However, claims for observation services over 24 hours will be allowed up to 48 hours. Excess services/observation time over 48 hours will be denied, with the exception of services for our Public Program members. Observation services/time between 49-72 hours will be reviewed for our Public Program members. All observation services over 72 hours will be denied.

Transfer Case

A transfer case is defined as a patient who is being discharged from one facility to another.

Patient status codes are a required field on the institutional claim (837I). This code indicates the patient’s status as of the “Through” date of the billing period. It is important to note that the patient status code indicates a destination and not a level or type of care received.

When a patient is transferred/discharged to another facility, patient status may affect reimbursement. All patient status codes are accepted but not all will result in a transfer case classification. The following patient status codes are used by Blue Cross to classify a transfer case.

Code	Definition
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
05	Discharged/Transferred to a Designated Cancer Center or Children’s Hospital Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at: https://www.cancer.gov/
43	Discharged/Transferred to a Federal Health Care Facility
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
70	Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List

Single facility claim submission

Blue Cross generally will **not** accept additional facility claims for the same encounter, normally referred to as late charges. To assure correct adjudication and payment of Health Services, Blue Cross requires all related services to be submitted on the same single facility claim (837I).

- **Late charges** – A late charge refers to those claims that Provider is submitting after an admit-through-discharge claim or for the same encounter. A late charge contains charges omitted from the original bill and the charges are submitted as an add-on to the original bill. A late charge bill is not allowed according to the Minnesota Uniform Companion Guide for Institutional Claims. It is also not allowed for paper claim submission.
- **Encounter** – Encounter means an instance of direct provider/practitioner to patient interaction, in an outpatient facility setting, for the purpose of diagnosing, evaluating or treating the Subscriber's condition, and during which Health Services are rendered to the Subscriber.
- **Exceptions** – Exceptions that may justify separate claims may include:
 - **Separate ER visits** – separate emergency room visits on the same date of service
 - **Ambulance services**
 - **Late charges – unrelated diagnosis:** Outpatient charges with same date of service submitted as separate claims with unrelated diagnosis will no longer be denied as late charges. The duplicate review process has been updated with the following examples of exceptions to late charge (replacement claim) processing. Use these as a guide to determine if the claim situation meets the criteria as 'unrelated.'
 1. Subscriber has a mammogram, subsequently, in another department, the Subscriber received chemotherapy (for other than breast cancer).
 2. Subscriber receives therapy, subsequently, in another department, the Subscriber has an electrocardiogram.
 3. Subscriber is seen for a radiation therapy, subsequently, in another department, the Subscriber is seen for routine screening.
 4. Subscriber receives therapy and subsequently visits the ER for a unrelated condition (for example, injury or acute illness unrelated to the therapy received)

Zero Billed Charges

Blue Cross will allow zero-billing or no charge submission lines on claims.

Lactation Education

For billing purposes, lactation services are considered to be part of the mother's charges and should not be billed on the newborn's claim.

Submit all claims for lactation education on the 837I claim form using revenue code 0942. These charges must be submitted on the mother's original maternity/delivery claim and require a narrative description.

Claims for lactation services submitted under the infant's name or number will be rejected.

If lactation education is necessary after discharge, it can be billed as part of the post-partum visit under the mother's identification number.

0636 Drugs Requiring Prior Auth

Revenue code 0636, by definition, is for drugs requiring detailed coding. A HCPCS code must always be submitted with 0636. However, some drugs that may be submitted under this revenue code also require prior authorization. The following are examples that require prior authorization:

- IVIG
 - Aminolevulinic Acid
 - Factor products
-

Present on Admission (POA)

Blue Cross requires the present on admission (POA) indicator on all claims (Medicare and commercial products), for inpatient admissions to general acute care hospitals.

General Reporting Requirements

- The POA indicator is required for all claims involving Medicare and commercial inpatient admissions to general acute care hospitals.
- The POA indicator is assigned to principal and secondary diagnoses.

Present on Admission (POA) (continued)

- Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter while in the emergency room, under observation or during outpatient surgery are also considered as present on admission.
 - If the condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current coding guidelines, then the POA would not be reported.
 - The POA indicator is not required for the external cause of injury code unless it is being reported as an “other diagnosis.”
 - Critical Access Hospitals, Maryland waiver hospitals, long-term care hospitals (LTCH), cancer hospitals and children’s inpatient facilities are exempt from this requirement.
 - Use the POA indicators as they would normally be submitted to Medicare. For more information, refer to cms.hhs.gov/HospitalAcqCond
-

Claims Filing

Timely Filing

Most Subscriber Contracts contain a time limit for claims submittal. Timely filing for Federal Employee Program (FEP) Subscribers can be found in Chapter 5- ID Cards/Coverage Options. Providers are required to submit original claims within 120 days of the date of service for dates of service prior to January 31, 2023. Providers are required to submit original claims within 180 days of the date of service for dates of service on and after February 1, 2023. Provider is liable for claims not submitted within the timely filing limit.

For medical care that involves follow-up, such as surgery and routine postoperative care, it is most efficient to bill Blue Cross after all Health Services have been completed, as long as it is within the time limit.

Exceptions

The following are exceptions to the timely filing limit:

- Blue Cross and Blue Shield of Minnesota is secondary
- Patient has died during timely filing period
- Patient has Medicare as primary
- Original receipt date of service is within timely filing
- Claim is a Medicare replacement or provider replacement claim that has been converted to an original
- If another insurance company is identified as the payer and the provider bills the other payer within the timely filing guidelines. These claims would have to be appealed and supporting documentation is required.
- If the patient is identified as the payer and the provider bills the patient within the timely filing guidelines. These claims would have to be appealed and supporting documentation must include notes about accounts receivable actions. For example, include notes about documenting calls with the Blue Cross Service Center or notes that the member was sent to collections within 120 days after the date of service through January 31, 2022 or within 180 days after the date of service beginning February 1, 2023.
- Retro enrollment into an Exchange product.
- Documentation attached to claim indicating one of the above situations exists and supports waiving the timely filing guidelines.

**Timely Filing
(continued)****Public Programs Claims Filing Exception**

Due to the unique nature of the services provided, Blue Cross and Blue Plus has made a change to the timely filing contract provision for providers exclusively participating with Blue Cross to serve Minnesota Health Care Programs (MHCP) subscribers.

These providers will continue to have a 180-day timely filing period. This means that claims need to be submitted no later than 180 days from the date of service. This change is retroactive to January 1, 2013.

Replacement Claims

Blue Cross' requirements for timely filing of replacement claims is six calendar months from the process date of the predecessor claim.

There is no timely filing limit on cancel claims (claim frequency code of 8).

Provider-Submitted Appeals

Blue Cross' requirement for timely filing of provider-submitted appeals is 90 days from the remittance date of the claim.

In no event may Provider send a replacement claim with no data changes to the payer in order to extend the 90 days allowed from remittance date of the claim to appeal.

Claims Crossover for Medicare and Medicare Supplement

The claims crossover system reduces Provider's paperwork by using the Medicare claim form to process both Medicare and Medicare Supplement benefits. Through the crossover, Medicare generates a second claim automatically for Subscribers who have secondary or supplemental benefits with Blue Cross. Providers have only one claim form to submit—the 837P for Medicare Part B or the 837I for Medicare Part A.

While Blue Cross can only accept changes from the Subscriber, it encourages Providers who are aware of Medicare Beneficiary Identifier (MBI) (formerly HICN) changes to assist their patients in communicating this information to Blue Cross.

Medicare Crossover

Blue Cross provides COBC a bi-weekly eligibility file of all Blue Cross Subscribers enrolled for coverage under the Medicare program where Medicare is the primary payer. When Medicare processes a claim, the Medicare Subscriber's MBI will be compared to the MBI on the eligibility file sent by Blue Cross. If found, the date of service on the Medicare claim will be compared to the Blue Cross coverage effective and cancel dates. If the claim's date of service falls within those dates, the claim will be crossed over to Blue Cross electronically.

837I Crossover Information

The current message indicating the claim was sent to Blue Cross will continue to be displayed on the Subscriber's *Medicare Summary Notice (MSN)* or on the *Explanation of Medicare Benefits (EOMB)*. Medicare will indicate on Provider's Remittance Advice (RA) if the claim was sent to the supplemental insurer. On the Intermediary RA, claim status codes of 19, 20 or 21 indicate that the claim was crossed over. If the MBI is not found on the Blue Cross eligibility file, or if the date of service on the claim is outside the given Blue Cross coverage effective and cancel dates, the claim will not be forwarded to Blue Cross electronically.

**837P Crossover
Information**

A note associated with the ANSI remark code indicates which payer will receive the claim information. Provider will continue to see MA18 and the name of the payer on the Medicare RA when the payment information is forwarded to a single payer. However, code N89 will be used when the payment information is forwarded to multiple payers; only one of those payers will be named on the RA even though the payment information is forwarded to multiple payers.

Paper claims submitted to Blue Cross with the Medicare RA attached and the N89 remark code stating the payment information was forwarded to Blue Cross will be returned to Provider. Adjusted Medicare B claims will not be crossed over to Blue Cross.

If the claim is not forwarded, then:

- The statement or code indicating the claim was forwarded to Blue Cross will not appear on the MSN, EOMB or RA.
- The Subscriber or Provider must submit the electronic claim to Blue Cross populating Medicare's payment information within the claim record.

Duplicate Claims

Duplicate billing adds millions of dollars each year to health care administrative costs. Many providers operate under the erroneous assumption that frequent rebilling leads to faster payment. Unnecessary rebilling increases providers' overhead costs as well as those of Blue Cross. Below are several ways providers can help reduce duplicate claims costs:

- When filing the claim, be sure to tell Subscribers not to bill on their own.
- Eliminate “automatic” rebillings. Wait 30 calendar days for Blue Cross to process a claim.
- Before rebilling, use www.availity.com, call BLUELINE®, use a 276/277 transaction or call provider services for claim status information.
- Don't submit previously billed claims with new claims “just to be safe.” This only delays payment of all new claims.
- Upon receiving a Medicare RA showing that the claim has electronically been “crossed over” to Blue Cross, do not submit the paper RA as a claim.
- If a claim has been denied, resubmitting the paper RA will only result in a second denial. Either correct fields on the claim and submit a replacement claim or submit an appeal as appropriate.

Submission of Claims

Blue Cross' goal is to pay claims as quickly as possible. By following the above suggestions, providers can help hold down everyone's administrative costs.

To ensure the proper administration of benefits by Blue Cross, Provider shall submit claims to Blue Cross even when its claims have been paid in full by other third parties such as Medicare. When submitting claims in these cases, Provider shall populate the previous payer's payment information within the claim.

Provider shall submit claims to Blue Cross for all Health Services provided, even in cases when Provider suspects a Health Service will not be covered. This will ensure the proper administration of benefits and take advantage of changes in coverage that may occur after Provider checks benefits.

Provider must submit claims to Blue Cross electronically in most cases. Upon reasonable advance written notice to Provider, Blue Cross may refuse to process paper claims, or charge Provider for processing paper claims. Both Provider and Blue Cross are subject to Minnesota Statute, Section 62J.356 and other applicable laws, regulations or guidance that governs electronic claims submission.

Blue Cross reserves the right to verify the clinical accuracy of claims through its claims systems. All Health Plan administration including application of benefits and patient eligibility is applied after clinical correctness has been established. Provider must comply with coding and billing requirements based on coding rules of CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS, HCPCS, HIPAA mandated Technical Report Type 3 documents and/or Minnesota Department of Health Uniform Companion Guides, including any updates or changes to such coding rules and/or guides as applicable and as interpreted by Blue Cross and as set forth in the coding policies and guidelines of the Provider Policy & Procedure Manual. Provider further agrees to submit claims for Health Services to Blue Cross in the most cost effective manner when more than one billing option exists. Provider is responsible for obtaining any authorization required to release such information to Blue Cross and/or the Plan Sponsor.

Cancel/Void and Replacement Claims

Minnesota statute 62J.536, requires providers to submit all claims electronically. This requirement includes all cancel and replacement claims as well as original submissions. Cancel claims are claims that should not have been billed or where key claim information such as the billing provider or patient name were submitted incorrectly. Replacement claims are sent when data submitted on the original claim was incorrect or incomplete.

Minnesota providers and out of state providers who participate with Blue Cross are no longer allowed to submit adjustment requests via paper or through provider web self-service. Providers are required to adhere to the State of Minnesota Uniform Companion Guide requirements and the AUC Best Practices for replacement claims. Additionally, provider services will no longer accept requests to change data elements within a claim as these should be sent electronically as replacement claims. Provider services will still accept requests to adjust claims in situations where the claim processed incorrectly even though correct information was provided on the original submission.

Exceptions

Exceptions to this electronic replacement claims enforcement are as follows:

- Dental formatted adjustment requests will still be accepted if received on paper.
- Pharmacy formatted adjustment requests will still be accepted if received on paper.
- Nonparticipating providers that are located in counties that border Minnesota are exempt from the statute, therefore paper claims will still be accepted from these providers.
- Adjustment Requests received from the Veterans Administration (VA) and Indian Health Services.

Additional Information

If Provider is unable to send electronic replacement and/or cancel claims, Blue Cross has secured the services of Availity to provide a free web-based tool for provider data entry of claims. To learn more about submitting claims using Availity's no-cost web-based tool, go to [availity.com](https://www.availity.com).

Cancel/Void and Replacement Claims (continued)

Blue Cross and its affiliates have completed system changes to accept and properly adjudicate electronic cancel and replacement claims.

Following are some of the common questions related to proper submission requirements. Section A contains general information, and section B is for specific handling of coordination of benefits (COB) related scenarios.

Section A – General Information

1. What is an example of a replacement claim? I have read the AUC description and would like some clarity on these claims.

A replacement claim, to paraphrase the Minnesota Uniform Companion Guides for claims, is used to completely replace a previously submitted claim when data within the claim record is added, changed or deleted. An example would be a professional claim sent with all diagnosis pointers set to “1.” On review by the provider after original payment, it is determined the second procedure was done in reference to the third diagnosis on the claim. A replacement claim is sent to correct the diagnosis pointer on line 2.

See section 4.2.3.2 of the Minnesota Uniform Companion Guides and the related AUC *Replacement/Void Claims Best Practice* available on the AUC website at:

[Home - MN Dept. of Health \(state.mn.us\)](http://state.mn.us)

2. Can I send a replacement claim if I have the wrong Subscriber ID on the previous submission?

No. According to the AUC *Replacement/Void Claims Best Practice*, “When identifying elements change, a void submission is required to eliminate the previously submitted claim.” Changes to identifying information related to the billing provider, patient, payer, Subscriber or statement covers period dates, require that a cancel claim transaction be submitted for the original claim and that a new claim with the corrected information be submitted to the payer. These requirements are similar to the Centers for Medicare & Medicaid Services (CMS) requirements.

3. Can I send an attachment on a replacement claim?

Yes, if it is relevant to the changes being made on the replacement claim or needed to support a particular coding change. For example, the addition of a -59 modifier to indicate that the Health Service being billed is a distinct procedure or service will require supporting medical documentation to be submitted with the replacement claim.

Cancel/Void and Replacement Claims (continued)

- 4. If Blue Cross denied my claim because the date of injury was required but not submitted in the claim, can I send an AUC Appeal Request Form to have the claim reconsidered and list the requested date of injury in the Reason for Appeal section?**

No. It is necessary to submit a replacement claim with the corrected data (injury date) in the 837 transaction.

- 5. What is an appeal?**

The Minnesota Uniform Companion Guides describe an appeal as “Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.” For example, the provider receives a claim denial because Blue Cross considered the procedure investigative. The provider's request to reconsider must be submitted on the AUC Appeal Request Form along with supporting documentation following the instructions in the AUC Submission of Appeals Best Practice. Fax the AUC Appeal Request Form and supporting documentation to Blue Cross at **(651) 662-2745**.

- 6. What are some examples of reasons for appeals?**

The following is a list of reasons to send an appeal, according to the Minnesota Uniform Companion Guide(s) for Claims:

- Timely filing denial
- Payer allowance
- Incorrect benefit applied
- Eligibility issues
- Benefit accumulation errors
- Medical policy/medical necessity

- 7. All of the claim information was submitted correctly; however, it appears not all claim data I sent was recognized by the system. Is it acceptable for me to call Blue Cross to simply have my claim adjusted using what was previously submitted or do I need to appeal?**

It is acceptable for providers to request the claim be adjusted to recognize the data within the submission through a phone call to provider services. It would also be acceptable for providers to submit a request using the AUC Appeal Request Form.

Cancel/Void and Replacement Claims (continued)

8. I am sending documentation in response to a request for additional documentation from Blue Cross. Do I need to send a replacement claim with the attached medical records?

If the provider is responding to an information request letter sent by Blue Cross, regardless of whether the provider also received a denial on its remittance, the provider should submit the requested information, along with a copy of the information request letter. Do not send an AUC Appeal Request Form. These same instructions are included on the letter that the provider receives.

9. I am sending documentation in response to a denial on my remittance advice from Blue Cross. Do I need to send a replacement claim with the supporting information needed?

If the provider is sending the additional documentation as a result of a denial on a remittance advice only, and not in response to an information request letter from Blue Cross, and the claim requires changes to claim data elements (such as date of injury, procedure code changes, diagnosis code changes, etc.), then a replacement claim must be sent which includes any necessary attachments.

If the provider is sending the additional documentation as a result of a denial on a remittance advice only and the claim does not require changes to claim data elements the provider also may send a replacement claim.

If the provider is sending additional documentation because it believes it did not receive correct payment and this documentation supports its position, the provider must send the AUC Appeal Request Form along with the documentation to support its request.

Section B – COB Related Scenarios

1. How do I send COB information when it was not included with the previous submission?

- **Scenario 1**

If the provider received a HIPAA compliant remittance advice (835), and the provider's system has the capability to populate the information within a secondary claim, the provider must submit a replacement claim with the data appropriately entered within the claim record.

Cancel/Void and Replacement Claims (continued)

- **Scenario 2**

If the provider has not received a HIPAA compliant remittance advice (835) from the previous payer, the provider may send a replacement claim transaction with the addition of the PWK segment and send the paper remittance advice from the previous payer as an attachment.

Note: All Minnesota Group Purchasers must provide a HIPAA and State of Minnesota compliant remittance advice, and providers are required by the Minnesota Uniform Companion Guides (section 4.2.3.5) to submit the previous payment information electronically using the proper fields within the claim transactions.

Additional Information

For additional information on these types of claims, please refer to the Minnesota Uniform Companion Guides and related Best Practice documentation on the AUC website at:

[Home - MN Dept. of Health \(state.mn.us\)](http://state.mn.us)

Release of Medical Records

The Minnesota Statute that states “consent for the release of medical records are valid for only one year,” also provides that consents to release medical records to insurers for purposes of claims payment do not expire after one year. Since there are circumstances where such consents are only valid for one year, providers may wish to update their records on an annual basis.

Provider Assistance Requested

Provider is reminded that:

- Per the Provider Service Agreement, Blue Cross or the Plan sponsor may reasonably request any additional information that is needed to respond to claims.
 - HIPAA considers release of such records as required for “business operations.”
 - ADHIs are required under Minnesota law.
 - Provider should gather information from Subscribers on an annual basis to facilitate timely processing of Subscribers claims.
-

Medical Records Management Process Improvement

Blue Cross is improving its medical records management process to better serve Providers.

- **Reduced requests** - Changes to the Blue Plan internal medical records procedures will eliminate unnecessary medical record requests and expedite claims processing for Subscribers from other Blue Plans.
 - **Clearer instructions** - A form will accompany all medical record requests to facilitate claims processing. The form should be returned with the requested records.
-

Verify Member Identity

Blue Cross has received a number of calls from its Subscribers who have stated that they did not receive certain Health Services that were billed under their Subscriber identification number.

Upon comparing consent for treatment forms with signatures on file it appears that such Health Services were provided to an imposter.

In order to prevent this occurrence, Provider should take appropriate steps to verify a Subscriber’s identity, such as viewing a government issued identification card and a Blue Cross Subscriber ID card at each encounter.

If a Provider suspects fraudulent use of a Subscriber ID card, please call Blue Cross' fraud hotline at **(651) 662-8363 or Toll Free 1-800-382-2000, ext. 28363**. Callers may remain anonymous.

Verifying Patient Eligibility

Minnesota Statute 62J.536 requires health care providers and group purchasers (payers, plans) to exchange eligibility information electronically using a standard format. The intent of the law is to reduce costs, simplify and speed up health care transactions, and give providers and Health Plans one set of rules to follow for electronic transactions. This statute applies to all health care providers that request benefit or eligibility information regardless of participating status.

Rules for Checking Eligibility and Benefits

According to the Minnesota Department of Health, the compliant modes for initial eligibility inquiries and responses are either via **www.availity.com** or submission of the *Eligibility Inquiry and Response Electronic Transaction* (ANSI ASC X12 270/271). Utilization of the Integrated Voice Response system (IVR) is not considered compliant for this initial exchange. If, after an initial compliant exchange (via web or EDI), additional information or review is needed, other modes that are available may be used, including IVR or a phone call to a service representative.

The AUC has published a best practice related to checking eligibility and benefits for patients. The best practice covers 4 major areas:

- When and how to verify
- Preferred methods of eligibility inquiry
- Sharing eligibility information
- Data elements that should be used to update information systems

The recommendation of the AUC is that eligibility be checked for each patient once per calendar month since most eligibility changes occur at the beginning of a month. Please refer to the best practice at the following link for other helpful tips:

[Home - MN Dept. of Health \(state.mn.us\)](http://state.mn.us)

Questions?

To register to receive the electronic eligibility (270/271) transaction, contact Availity at [availity.com](http://www.availity.com).

Basic Character Set Values in the Electronic Transaction

The AUC has published a best practice regarding utilization of the basic character set values within the transaction data.

The basic character set includes some punctuation characters and spaces. These values when used unnecessarily can cause issues with matching to the payers' enrollment for Provider or the Subscriber; or may cause the data to be incorrectly extracted/interpreted within the payers' applications.

If any of the punctuation characters within the basic character set are used as delimiters then they cannot be used in the transmitted data within a data element.

Punctuation and spaces should only be utilized within the elements when they add value to the data. They should not be used when their usage is not essential to the interpretation of the data content.

Basic character set: uppercase letters (A-Z), numeric digits (0-9), space (), exclamation point (!), double quote (“), single quote (‘), ampersand (&), right parenthesis, left parenthesis, asterisk (*), period (.), plus sign (+), comma (,), hyphen (-), forward slash (/), colon (:), semicolon (;), question mark (?), and equals sign (=).

Even though the “@” character is in the extended character set it is allowed for email addresses within the PER segment. This character must not be used as a delimiter.

Examples to illustrate best practice:

Description	Incorrect Examples	Correct Example
Name Titles (no period should be used).	JR. MR. PhD. M.D.	JR MR PHD MD
Address – no periods should be used as part of the address.	P.O. AVE.	PO AVE
Commas and periods should be used at the end of a sentence in a text field to separate from another sentence within the text field.	A PERIOD WITHIN A SENTENCE MAY HAVE VALUE DESCRIPTION OF SERVICE IS ABC	A PERIOD WITHIN A SENTENCE MAY HAVE VALUE. DESCRIPTION OF SERVICE IS ABC.

Basic Character Set Values in the Electronic Transaction (continued)

Description	Incorrect Examples	Correct Example
Hyphens and apostrophes should not be used within a last name field.	SMITH-JONES O'BRIEN	SMITHJONES OBRIEN
Leading and trailing spaces within fields should not be used.	Rendering practitioner last name = “_JONES” or “JONES_”	Rendering practitioner last name = “JONES”

Claim Service Dates Restricted to Same Calendar Month

The AUC has published a best practice regarding claim service dates in the same calendar month. The purpose of this best practice is to avoid split claims and rejections. Most eligibility changes occur at the beginning or end of a calendar month. Some payer systems require that claims contain only Health Services that are associated with a particular eligibility period. Current practice is to split these claims at the payer site to push through systems or to reject the claim.

On a professional claim, service date spans should only be within the same calendar month. Multiple claims may be submitted for different dates within the same calendar month based on the provider’s billing practices.

On an institutional outpatient claim, statement and service date spans should only be within the same calendar month. Observation, extended recovery and emergency department services beginning before and completing after midnight are exceptions to this best practice if performed during the same visit. Procedures beginning on one day and ending on another should be billed together.

This best practice does not apply to an institutional inpatient claim.

Pharmaceuticals should be billed with the administration/dispensed date rather than a span of dates.

Monthly equipment rental should be billed with the start date of the rental period only rather than the span of days.

Equipment rented on other than monthly basis needs both from and through dates. Units of service should be reported as one (1) per rental period. These service date spans should only be within the same calendar month. Example would be daily rental of equipment.

Supplies should be billed with the purchase date rather than the span of days.

**Claim Service Dates
Restricted to Same
Calendar Month
(continued)**

Refer to Appendix A of the MN Uniform Companion Guides for additional guidance on service date coding.

Examples to illustrate best practice:

Example 1 (equipment rental single month):

Equipment is rented for January 17 through February 16. Service date should be reported as January 17 with no end date.

DTP*472*D8*20080117~

Example 2 (equipment rental multiple months):

Equipment is rented for March 3 through May 15. Should be submitted as three separate claims, claim one would be reported as March 3 with no end date; claim two would be reported as April 3 with no end date; claim three would be reported as May 3 with no end date.

DTP*472*D8*20080303~

DTP*472*D8*20080403~

DTP*472*D8*20080503~

**Reporting MNCare and
Sales Tax**

Instructions for MNCare Tax billing only apply if Provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document **DOES NOT** require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT. Sales tax instructions for professional claims are as follows:

- MNCare Tax must be reported as part of the line item charge and reported in the corresponding AMT tax segment on the lines.

Rural Health Clinics and Federally Qualified Health Centers

Billing for Medicare Primary

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are Medicare provider designations. Medicare requires RHCs and FQHCs to bill services on an institutional format (837I).

Since billing as a RHC or FQHC would be secondary to Medicare, Blue Cross will only accept these clinic claims on the 837I.

The claim should be submitted following Medicare billing guidelines (for example, TOB 071X and revenue code 0521 for a clinic visit to an RHC).

Billing Other Than Medicare Primary

If Medicare is not primary, Health Services must be billed to Blue Cross as a clinic, not as an RHC/FQHC, under Provider's Blue Cross clinic provider number or NPI and submitted as a professional claim 837P.

Coordination of Benefits (COB)

Overview

Third-party payers rely on Coordination of Benefits (COB) to eliminate duplicate payments when a Subscriber has more than one coverage for Health Services. Please complete the information under “other coverage” on claims for Blue Cross Subscribers. List the names of any other carriers and the Subscriber’s ID number, if possible. Blue Cross determines which carrier is primary payer and ensures that duplicate payments are not made for the same Health Services.

Primacy Determination

Blue Cross follows the National Association of Insurance Commissioners (NAIC) rules to identify the primary insurance carrier.

Coordination of Benefits Types

There are several types of coordinating benefits. The only way to determine what type of COB a Subscriber has is to contact provider services.

1. The primary carrier pays appropriate benefits under its contract.
2. The claim is submitted to the secondary plan's carrier.
3. The secondary plan will never pay more than it would pay in the absence of coordination.
4. The secondary plan may leave the member liable for a portion of their plan cost share depending on the Subscriber contract.

Note: When coordinating benefits with Medicare all COB Types coordinate up to Medicare's allowed amount when Provider accepts assignment and Provider is located within the state of Minnesota. The federal Medicare Secondary Payer (MSP) law dictates when Medicare pays secondary.

When coordinating benefits with another commercial carrier all COB types coordinate up to the higher allowed amount between the two plans except when integration is involved. Integration will coordinate up to Blue Cross' allowed amount.

It is important that all charges submitted to the primary payer be submitted to the secondary payer, even though charges were paid in full.

Workers' Compensation

In cases where an illness or injury is employment-related, Workers' Compensation is primary. If notification is received that the Workers' Compensation carrier has denied the claim, Provider shall submit the claim to Blue Cross regardless of whether the case is being disputed. It is also helpful to send the other carrier's denial statement with the claim.

No-fault Auto

The No-fault Automobile Insurance Act calls for automobile insurance coverage to be primary without regard to cause or fault for the accident. The health insurance carrier would be the secondary payer. If notification is received that the no-fault auto carrier has denied the claim, Provider shall submit the claim to Blue Cross regardless of whether the case is being disputed. It is also helpful to send the other carrier's denial statement with the claim.

Subrogation

Subrogation literally means the substitution of one person for another. It is the right to recover payments for a Subscriber whose personal injuries are caused by the negligence or wrongdoing of another person. Minnesota does not have specific statutes or laws that apply to subrogation. Some group health care coverage plans and Blue Plus do have subrogation in their certificates or Provider Service Agreements. For those groups, Blue Cross will initially pay the claim until the case is settled.

Non-Physician Health Care Professionals

Introduction

Blue Cross will pay for reasonable and necessary Health Services performed by certain non-physician Health Care Professionals. Eligible Health Services are determined by the Health Care Professional's scope of practice and the Subscriber's Contract.

Eligibility Criteria

Below is the eligibility criteria for non-physician Health Care Professionals:

- Non-physician Health Care Professionals must meet applicable state or federal laws or licensing standards.
 - When collaboration is required, non-physician Health Care Professionals in independent practice must work in collaboration with a physician licensed in the state where the Health Services take place.
 - A non-physician Health Care Practitioner not eligible as an independent contractor must be an employee of a physician or limited-license practitioner (such as chiropractor or optometrist) licensed in the state where the Health Services took place. The employing provider must be legally and medically responsible for the supervised employee's services.
 - Behavioral health clinical trainees or interns may provide behavioral health services such as psychotherapy, diagnostic assessments, and treatment plans under the supervision of a licensed behavioral health professional.
 - Eligible non-physician Health Care Professionals must apply for and meet Blue Cross credentialing criteria.
 - Non-physician Health Care Professionals must use their NPI or Blue Cross individual provider number when submitting claims.
 - Health Services rendered by supervised employees who are not issued individual provider numbers must be submitted under the supervising physician or behavioral health professional's NPI with modifier -U7 appended to the HCPCS code.
 - Health Services must be provided in accordance with the provisions of the Provider Service Agreement.
 - A countersignature of notes and orders by the employing or supervising physician is required if the non-physician Health Care Practitioner's licensure and/or scope of practice requires a signature.
-

Definitions

Centers for Medicare and Medicaid Services (CMS) guidelines are the basis for the following definitions. For added clarification, Blue Cross has further defined supervision as either direct or general.

Employment

As defined by CMS, the non-physician performing an “incident-to” service may be a part-time, full-time or leased employee of the supervising physician group practice or the legal entity that employs the supervising physician. A leased employee is a non-physician working under a written employee leasing agreement, which provides that:

- The non-physician, although employed by the leasing company, provides Health Services as the leased employee of the physician or other entity; and
- The physician or other entity has control over all actions taken by the leased employee with regard to medical Health Services rendered to the same extent that the physician or other entity would have such control if the leased employee were directly employed by the physician or other entity.

To satisfy the employment requirement, the non-physician must be considered an employee of the supervising physician or other entity under the common law test of an employer/employee relationship.

Health Services provided by auxiliary personnel not employed by the physician, physician group practice, or other legal entity are not covered as incident to a physician’s service.

Incident To

“Incident to” physician’s professional services means that the Health Services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment or an injury or illness.

- The Health Care Practitioner’s service must be furnished as an integral part of the physician’s personal professional service in the course of diagnosis or treatment of an illness or injury.
- An employee of the physician must render service under the physician’s direct supervision.
- The physician must perform the initial and subsequent service with a frequency that reflects his/her active participation in managing the course of treatment.

Health Care Professionals who are issued individual provider numbers are considered incident to the physician when performing Health Services within the same encounter on the same day as the physician.

Incident to services are applicable in the office place of service only.

Direct Supervision

The physician must be present in the office suite and immediately available to assist and direct throughout the performance of the Health Service. Direct personal supervision does not mean that the physician must be present in the same room with the non-physician practitioner. A physician cannot provide direct or personal supervision via telemedicine. Direct supervision is only applicable in the office place of service.

General Supervision

General supervision refers to Health Services furnished under the physician's overall direction and supervision. The physician does not have to be physically present in the same office suite. He or she may provide general supervision by periodic review of the non-physician's practice and availability either in person or through electronic communications (telemedicine, telephone, etc.).

**Collaboration/
Independent Practice**

Certain Health Care Professionals are qualified to set up their own practice. Although these Health Care Professionals work independently and do not require physician supervision, they must work with or collaborate with a physician. For example, a physical therapist may perform therapy independently; however, the Subscriber's physician makes the initial determination that the Subscriber requires or will benefit from physical therapy. The physical therapist works in collaboration with the physician.

**Chiropractic Doctors
and Multidisciplinary
Clinics**

Chiropractic doctors must maintain separate Provider Service Agreements and provider numbers when practicing in a multidisciplinary clinic setting with medical doctors. Blue Cross does not allow chiropractors to bill services as "incident to" a physician's services. Services performed by a chiropractor must bill under the chiropractor's own provider number.

The assignment of a chiropractic provider number is fundamental to the appropriate processing of Blue Cross' Provider Service Agreements and Subscriber Contracts. It allows Blue Cross to identify the specialty of the individual providing the services. This is especially important to enable Blue Cross to correctly administer those Provider Service Agreements and Subscriber Contracts that have visit limitations, exclusions and other benefit variances.

A multidisciplinary clinic with medical and chiropractic doctors must adhere to the requirement that independently licensed chiropractors must maintain separate Provider Service Agreements with Blue Cross and bill appropriately. There are no exceptions to this policy. Any deviation from this billing requirement is a violation of the Blue Cross Provider Service Agreement.

Surgical Technicians and MBBS Practitioners

Surgical technicians are considered to be hospital-based Health Care Professionals and as such cannot have an independent relationship with Blue Cross nor can their services be billed under a supervising physician's individual provider number. Surgical technicians are members of the operating team that prepare the patient and the operating room for surgery, transport patients, observe vital signs and check charts during surgery.

Likewise, Bachelor of Medicine and Bachelor of Surgery (MBBS) practitioners are not recognized separately or allowable to bill for assistant surgery services and will be denied as ineligible.

Mid-level Practitioners

Blue Cross defines mid-level practitioners according to their specialties. The practitioner's specialty is established based on their current state license and is appropriately determined during the credentialing process.

The following is a comprehensive current list of mid-level practitioners:

- Adult Nurse Practitioner
- Certified Nurse Midwife
- Certified Registered Nurse Clinical Specialist in Mental Health
- Clinical Nurse Specialist
- Family Nurse Practitioner
- Gerontological Nurse Practitioner
- Neonatal Nurse Practitioner
- OB/GYN Nurse Practitioner
- Pediatric Nurse Practitioner
- Physician Assistant
- Psychiatric Mental Health Nurse Practitioner
- Registered Nurse First Assistant

Mid-Level Reduction Exemption

Retail Health providers and online care providers are exempt from the mid-level reduction as defined in the provider contract.

Masters Level Practitioners

Blue Cross defines masters level practitioners based on practitioner specialties. The practitioner's specialty is established based on their current state license and is appropriately determined during the credentialing process. The following is a comprehensive current list of masters level practitioners:

- Board Certified Behavioral Analyst (BCBA)
- Certified Marriage and Family Therapist
- Certified Professional Counselor
- Licensed Marriage & Family Therapist *
- Licensed Nutritionist
- Licensed Prof. Clinical Counselor *
- Licensed Professional Counselor *
- Licensed Psychologist MA *
- Registered Dietician
- Social Work

*Indicates master level practitioners who can see Medicare Advantage members only if they are under general supervision. This applies only to Medicare Advantage members.

Chapter 9

Reimbursement/Reconciliation

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Reimbursement

Payment Methodology Additional information regarding payment methodology is available in the Provider Service Agreement.

Definitions:

"All Patient Refined DRGs" (APR-DRG)" means the 3M™ classification system that forms a clinically coherent set of severity of illness and risk of mortality adjusted patient groups, designed to describe the complete cross-section of patients seen in acute care hospitals as specified in the Attachment A Rate Table of the Provider Service Agreement, if applicable.

"APR-DRG Base Rate" means the negotiated dollar rate per Relative Weight of One (1.0) indicated in the Attachment A Rate Table of the Provider Service Agreement used to calculate the APR-DRG Case Rate for a given APR-DRG category.

**Payment Methodology
(continued)**

"APR-DRG Outlier Threshold" means the Outlier cost threshold established for each APR-DRG.

When the Case Cost for the APR-DRG exceeds the APR-DRG Outlier Threshold, additional reimbursement may be realized in addition to the calculated case payment. An example of calculating an additional payment for an Outlier Case is as follows:

- Case Cost: facility charge (\$124,968) x facility applicable RCC (0.29) = Case Cost (\$36,241).
- Outlier Payment: Case Cost (\$36,241) – Outlier Cost Threshold (\$21,256) = Outlier Payment (\$14,985).
- APR-DRG Case Rate: Case Weight (3.0654) x Facility Base Rate (\$13,905) = APR-DRG Case Rate (\$42,624).
- Final Outlier Case Payment: APR-DRG Case Rate (\$42,624) + Outlier Payment (\$14,985) = Total Outlier Case Payment (\$57,609).

"APR-DRG Relative Weight" means the weight assigned to a specific APR-DRG which is intended to reflect the relative resource consumption related to the procedures and/or diagnoses associated with that APR-DRG. The relative weight assigned to each APR-DRG is calculated by Blue Cross and assigned a version number. See Attachment A-Rate Table of the Provider Service Agreement, if applicable, for the then-current Blue Cross version number.

- **"Base Period"** means the 12 month period prior to the Contract Period.
- **"Blue Cross Negotiation Model"** means the financial model utilized by Blue Cross to calculate Reimbursement Rates which yield the Negotiated Reimbursement Adjustment.
- **"Charge Description Master Adjustment"** means the actual percent change of the charge description master on the Data Set.
- **"Contract Period"** means the term of the contract for which the Reimbursement Rates apply.

**Payment Methodology
(continued)**

- **“Data Set”** means the claims incurred during the Contract Period.
- **“Enhanced Ambulatory Patient Groups” (EAPG)** means the 3M™ visit-based patient classification and payment system for ambulatory care and Health Services used to organize and pay Outpatient Health Services with similar resource consumption across multiple settings. See Attachment A-EAPG Rate Table of the Provider Service Agreement if applicable for the then-current patient classification version number.
- **“EAPG Ancillary Packaging”** means lower-level ancillary services are packaged and not considered for additional reimbursement.
- **“EAPG Base Rate”** means the negotiated dollar rate per Relative Weight of One (1.0) indicated in the Provider Service Agreement, if applicable.
- **“EAPG Multiple Services Discounting”** means a reduction in payment rate for multiple significant procedures, tests or therapies performed on the same day, repeat ancillary EAPGs, bilateral procedures and terminated procedures.
 - The highest weighted procedure is reimbursed at 100% of allowed
 - Additional procedures are reimbursed at 50% of allowed

**Payment Methodology
(continued)**

- **"EAPG Relative Weight"** means weight assigned to a specific EAPG which is intended to reflect the relative resource consumption related to the procedures and/or diagnoses associated with that EAPG. The Relative Weight assigned to each EAPG is calculated by Blue Cross and assigned a version number. See Attachment A-Rate Table of the Provider Service Agreement, if applicable, for the then-current Blue Cross version.
- **Interim Billing** Claims submitted with a patient discharge status code of 30 (still a patient or expected to return for outpatient Health Services) for inpatient stays beyond 30 days will be reimbursed according to the facility's interim billing payment percentage as indicated in Attachment A-Rate Table of the Provider Service Agreement. Claims submitted with the discharge status code 30 for stays less than 30 days are subject to post payment audit and potential recoupment of payment.

**Payment Methodology
(continued)**

- **"Medical Outpatient Visit"** (ambulatory surgery centers, hospital emergency departments and outpatient clinics) means all outpatient Health Services rendered within a single encounter or visit. If multiple outpatient Health Services are performed and submitted on a single claim with the same service date, it will be considered as one Medical Outpatient Visit. Claims with multiple dates of service will split into multiple Medical Outpatient Visits with the exception of emergency department, recovery and direct admit for observation claims. All claims must be submitted in accordance with Claims Submission Guidelines.
- **"Negotiated Reimbursement Adjustment"** means the aggregate reimbursement percentage change agreed upon between the Parties for the Contract Period.
- **"Ratio of Cost to Charge" (RCC)** means the ratio of Provider's cost (total expenses exclusive of bad debt) to its charges (gross patient and other operating revenue) as determined by the Provider's Medicare Cost Report.

**Payment Methodology
(continued)**

- **“Regular Billed Charges”** means the schedule of regular billed charges of Provider for Health Services. In no event shall Blue Cross’ Regular Billed Charges nor shall the Regular Billed Charges be higher than the charges for the same Health Services provided to a private pay patient who is not a Subscriber.
- **“Reimbursement Rates”** means the payment rates calculated during negotiations that produce the overall agreed upon Negotiated Reimbursement Adjustment.
- **“Reported Charge Description Master Adjustment”** means the expected percent change of the charge description master the Provider submits electronically to Blue Cross and is utilized to calculate the Reimbursement Rates. Chargemaster adjustment forms must be submitted promptly and provided separately for inpatient, outpatient and professional services.

**Payment Methodology
(continued)**

“Ungroupable DRG” means a DRG to which has assigned a Relative Weight of Zero (0).

“Case” Definitions:

1. **“EAPG Case Rate”** means the total amount paid for an Outpatient Case which is reimbursed using an EAPG and is either calculated by multiplying the EAPG Base Rate by the EAPG Relative Weight, or where an allowed amount has been specified for an EAPG, as specified in the Attachment A – Rate Table of the Provider Service Agreement. The EAPG Case Rate includes Blue Cross’ payment and amounts due from all other parties and will not exceed Provider’s Regular Billed Charge.
2. **“Negotiated Per Case Rate” or “Per Case”** means the dollar amounts used to determine Blue Cross’ total liability for all Health Services in an outpatient category, if applicable, of Health Services indicated in Attachment A-Rate Table. These payments include Blue Cross payment and all amounts due from all other parties.

**Payment Methodology
(continued)****Fee Schedules**

Effective July 1 of each year, Blue Cross implements the most current Relative Value Units (RVUs) as published in the Federal Register and as implemented by Blue Cross. Payment for Health Services not assigned RVUs shall be calculated at the then current applicable fee schedule as set forth in the Aware Provider Service Agreement.

A list of applicable fee schedule allowances is available to the Provider upon request by the Provider, up to twice annually. Provider must submit the request via email to

Fee.Schedule.Allowance.Request@bluecrossmn.com.

Blue Cross will not accept retroactive charge increases from the Provider. Payment amounts may be affected by Provider certification or Blue Cross credentialing criteria, as detailed in Chapter 2 of the Provider Policy & Procedure Manual.

For new programs of Health Services (e.g., pain, pulmonary rehabilitation, infant sleep apnea, the use of new technology, or services delivered at a particular site of service) the Provider agrees to give Blue Cross at least ninety (90) days advance written notice before implementing any such new program. Within ninety (90) days of receipt of such notice, Blue Cross shall notify the Provider that the service is covered, not covered, covered at a lower rate or at a different site of service. Blue Cross reserves the right to elect not to cover any new program or Health Service, require that certain services be delivered in a specific setting, or to apply a different payment arrangement for such program or Health Service. Blue Cross understands that care delivered in a higher cost setting with no improvement in outcomes does not support affordable, quality care. Blue Cross may determine that its existing networks already hold sufficient capacity for a particular Health Service.

Changes to Minnesota Health Care Programs and Medicare Payment

In the event that CMS or DHS has published rate or methodology changes, Blue Cross shall implement such changes within 90 days of the date that such change is effective or by the first day of the following calendar quarter after the changes are released, whichever is later, unless otherwise specified by the state or federal regulatory agency.

The Provider shall not request adjustments, and Blue Cross shall not adjust any claims paid prior to the effective date Blue Cross implements any such changes. Payment to the Provider for Health Services provided to Subscribers of the Minnesota Health Care Programs and Medicare Members shall be consistent with the Provider's licensure as reported to Blue Cross and as verified with the applicable licensing board.

Direct Payment

Blue Cross sends claims payments directly to participating providers. Payments are sent weekly.

Minnesota Statute 62J.536 requires all providers to accept from group purchasers the health care payment and remittance advice transaction (835). The statute further allows the use of web-based technology for complying with the requirements as long as the data content and rules of the Minnesota Uniform Companion Guides are followed.

Blue Cross does not print and mail *any* paper remittances. Provider must register through Availity to receive the electronic 835 or to view its remittance information.

A nonparticipating provider generally receives neither direct reimbursement from Blue Cross nor a copy of the statement for any Subscriber who has Blue Cross coverage. Subscribers cannot assign benefits to providers. Blue Cross pays Subscribers directly for nonparticipating Minnesota or border providers. However, the provider will be paid directly if the Subscriber has Minnesota Health Care Programs coverage.

Electronic Funds Transfer

Blue Cross offers Electronic Funds Transfer (EFT). Instead of weekly checks with remits, Provider can now receive electronic payments directly into its facility's checking or savings account. The funds are securely transferred via the Automated Clearinghouse (ACH) process.

Electronic payment will streamline the reconciliation process, eliminate deposit delays due to check handling, and improve cash flow.

The Provider Automatic Payment application is available at **bluecrossmn.com**; click on the Provider icon and then forms.

MNCare Tax

For those Health Services that are subject to the MinnesotaCare Tax, Blue Cross shall compensate Provider for such tax amounts. For all Health Services paid based upon a "fixed fee" method (for example, fee schedule amounts, per diem amounts, per case amounts, etc.), this means that Blue Cross shall add an amount representing the tax to such fixed payments (for example, if the fee schedule amount is \$100.00 and the then-current tax percentage is 1.6 percent, Blue Cross shall pay Provider \$101.60). Examples of fee schedules that do not include the MinnesotaCare tax are those for workers' compensation, HIAA, Federal Employee Program, out-of-state providers, and some specific provider types. For all Health Services paid at Regular Billed Charge or a percentage of Regular Billed Charge, the amount billed to Blue Cross by Provider shall be deemed to include the then-current tax amount and Blue Cross shall not increase its payment by the applicable tax percentage amount for such claims (for example, if Provider is paid on a 70 percent of Regular Billed Charge basis, and Provider's Regular Billed Charge is \$100.00, Blue Cross shall reimburse the Provider \$70.00). Provider agrees to accept such payments as payment in full from Blue Cross or the Plan Sponsor. If the amount of Blue Cross' MinnesotaCare tax payments for a given Health Service exceeds the amount of tax owed for that Health Service, Provider agrees to refund the excess to Blue Cross.

Inpatient Claims Paid at DRG Rates

Blue Cross pays inpatient claims at APR DRG (All Patients Refined Diagnosis-Related Group) rates for most hospitals.

About APR DRGs

Blue Cross reserves the right to update the APR DRG inpatient categories of care. APR DRGs are a way of categorizing inpatient hospital services by diagnosis groups that have similar patterns of hospital resource use. DRG assignment is based on the patient's diagnoses, procedure codes, age, sex, discharge status, and severity of illness. Payments are based on the assigned APR DRG weight, multiplied by a base rate (conversion factor) that Blue Cross negotiates with hospitals.

Coding Compliance

Coding compliance relates to the accuracy and completeness of the ICD-10-CM diagnosis and procedure codes that are used to assign DRGs and determine payment. Blue Cross requests that hospitals establish adequate internal procedures to ensure the accuracy of claims submissions. Blue Cross reserves the right to conduct random chart audits on a sample of records to ensure that diagnoses submitted justify the DRG and adhere to ICD-10-CM coding rules. Coding errors that are determined to represent a fraudulent claim may be subject to penalties.

Complication and Co-morbidity Defined

According to St. Anthony Publishing (Ingenix), a “complication” is a condition that arises during a hospital stay and prolongs the length of stay by at least one day in approximately 75 percent of the cases. The same source defines “co-morbidity” as a preexisting condition that, because of its presence with a specific diagnosis, will cause an increase in length of stay by at least one day in approximately 75 percent of cases. The condition must affect the patient’s hospital care by requiring one or more of the following:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic studies or procedures
- Increased length of stay
- Increased nursing care and/or monitoring

Although there is a standard list of diagnoses that are considered complications or co-morbidities, if the diagnosis does not require one or more of the above services, it should not be listed as a diagnosis. The provider must verify and document the conditions, based on clinical findings and treatment in the record.

Serious Preventable Medical Errors

When the negligence, omission, or error on the part of Provider results in the Subscriber incurring additional medical expenses, no payment will be made by Blue Cross for, nor shall Provider bill either Blue Cross or the Subscriber for said additional medical expenses. The National Quality Forum has defined certain events as serious preventable medical errors, and these are the situations for which no payment shall be made by Blue Cross or the subscriber.

A listing of these events can be found at www.qualityforum.org. This listing will be updated periodically by the National Quality Forum.

Examples of serious preventable errors include:

- Unintended retention of a foreign object in a patient after surgery.
- Patient death or serious disability associated with a medication error (for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration).
- Surgery performed on the wrong body part.
- Surgery performed on the wrong patient.
- Wrong surgical procedure performed on a patient.
- Infant discharged to the wrong person.

Replacement of Medical Devices

No payment will be made by Blue Cross and neither Blue Cross nor the Subscriber shall be billed for the cost of a replacement device in excess of the actual cost paid by Provider for the replacement device.

Provider is obligated to submit to Blue Cross proof of the actual payment amount made by Provider to the manufacturer or reseller of the replacement device for such replacement device and is likewise obligated to advise Blue Cross of any rebate, retroactive payment, warranty program payment and/or waiver of payment received from the device manufacturer or reseller.

This applies to, but is not limited to, devices subject to warranty replacement programs and/or recalls, whether or not such warranty replacement programs and/or recalls are due to device failures design defects and/or defective materials.

If a third party such as a medical device manufacturer or reseller recalls or replaces a device and Provider is either reimbursed for the cost of the device or is not charged for the replacement device, no charge for the device will be billed to Blue Cross or the Subscriber.

Provider shall bill only for the professional services associated with the replacement procedure; provided however, that no payment will be made by Blue Cross, and Provider shall not bill Blue Cross or Subscriber for any Health Service in the event that the Subscriber is held harmless by the manufacturer and/or other third party for such Health Services rendered in the removal of a defective device and/or insertion of a replacement device.

Overpayments

1. In the event Blue Cross makes a corrective adjustment, Blue Cross may deduct any overpayments from future payments owed to Provider together with an explanation of the credit action taken. Blue Cross shall be entitled to use a statistically valid sample when determining overpayment amounts. Blue Cross shall have the right to offset against any amounts due and owing or which become due and owing to Provider under the Provider Service Agreement, any amount (a) due and owing or which become due and owing to Blue Cross and/or any Affiliate under the Provider Service Agreement and/or (b) that may have been paid by Blue Cross and/or its Affiliates to Provider in error, including without limitation, payments made to Provider for non-covered Health Services. To the extent Blue Cross exercises the foregoing right to offset against claims for Health Services otherwise properly payable, such claims to which the offset is applied shall be deemed to be paid by Blue Cross, and Provider shall not have the right to balance bill Subscriber for such claim amounts.

Settlement for Hospitals

- A. Cases/Settlement Time Frame, if applicable. Settlements will be calculated and paid only on cases where Blue Cross has Primary Coverage Responsibility. Unless otherwise specified, a final settlement will be calculated by Blue Cross within 180 days after the applicable term ends, and will include a three-month run-out of claims data.
- B. Payment of Settlement. Blue Cross shall be under no obligation to complete any settlements if the Agreement has not been signed by Provider. Any amounts due to the Provider from Blue Cross will first be netted against any outstanding balances due to Blue Cross from the Provider. If no outstanding balance is due, Blue Cross will then pay the settlement amount to the Provider. If an outstanding balance is due Blue Cross, all such payments shall be made within ninety (90) days of when the settlement is sent by Blue Cross to Provider, or upon a mutually agreed upon payment plan. If payment is not received within the ninety (90) day period or an arrangement for payment has not been agreed upon, any unpaid amounts due Blue Cross will be collected in four (4) weekly amounts by reducing Blue Cross' future claim payments to the Provider.
- C. Non-Adjudicated Claims. In the event a claim or claim adjustment is not adjudicated prior to the three-month settlement run-out period, it will not be included in the settlement unless otherwise agreed to at Blue Cross' discretion.
- D. Settlement Amounts. Any settlement amounts (either due to or due from Provider) totaling less than one hundred dollars (\$100) in aggregate (across all Blue Cross lines of business) may be waived at Blue Cross' discretion. Provider agrees not to bill Subscriber for any such amounts which would otherwise be due from Blue Cross.

<p>Settlement for Hospitals (continued)</p>	<p>E. <u>Settlement Appeals.</u></p> <ol style="list-style-type: none"> 2. The Provider is entitled to one appeal and, if need be, one secondary appeal. After that, any unresolved issues will be resolved via a meeting and, if necessary, via the dispute resolution process described in the Arbitration provision of the Agreement. Secondary appeals must be submitted with additional information over and above what was submitted with the initial appeal. 3. Provider agrees to forward final settlement appeals, if any, to Blue Cross within ninety (90) calendar days of Provider's receipt of the final settlement. In the event of an appeal, the Provider still must make payment for the full balance due Blue Cross in accordance the payment of settlement provision. If such payment is not timely received by Blue Cross, any unpaid amounts due Blue Cross will be collected in four (4) weekly amounts by reducing future claim payments to Provider. 4. Blue Cross reserves the right to review, and, if necessary, correct the settlement in its entirety, upon Provider's appeal. Blue Cross is not limited to reviewing only appealed items. 5. Secondary appeals. Provider shall have sixty (60) calendar days from the date of receipt of Blue Cross' response to the original appeal, to submit a secondary appeal for the same original appeal. 6. Failure of Provider to appeal or submit a secondary appeal within the timeframe(s) specified herein; constitute a waiver of Blue Cross' obligation to review the appeal or secondary appeal <p>If Provider disputes Blue Cross' response to a secondary appeal, the Parties shall meet within 60 days to attempt to reach agreement on the completion of the final settlement. Provider shall provide Blue Cross with the reasons for its dispute and any needed background documentation prior to the meeting. Both Parties shall ensure that the appropriate staff members attend the meeting. The Parties shall be subject to the dispute resolution process described in the Arbitration provision of the Agreement if disagreement remains after the first meeting</p>
<p>Payment dispute for Emergency Services</p>	<p>In accordance with the CAA requirements for emergency services, effective January 1, 2022, Blue Cross and Provider, will have four days to successfully negotiate payment after a claim for emergency services is paid or denied by Blue Cross. If payment is not successfully negotiated, determination of out of network rates to be paid by Blue Cross shall be determined through an independent dispute resolution (IDR) process.</p>

Remittance Advice

Introduction

Weekly remittance cycles are run for original and adjustment claims that are provider payable, and for original and adjustment claims that are member payable and were completed on Friday.

Providers will receive a separate remittance for each line of business (Payer Name); BLUECROSS BLUESHIELD OF MINNESOTA, BLUECROSS BLUESHIELD BLUEPLUS OF MINNESOTA, FEP, Wilson McShane, CCS/TPA.

Electronic Remittance Advice (ERA) are accessible through Availity, Blue Cross' Clearinghouse at www.availity.com. Availity solutions for providers include a free, online Provider Portal for real-time information exchange with many payers as well as a premium all-payer tool to manage revenue cycle, reduce claim denials, and capture patient payments.

Claim Adjustment Group Code (Group Code)

Blue Cross follows the Committee on Operating Rules for Information Exchange (CAQH CORE) Code Combinations defined Business Scenarios and the MN Uniform Companion Guide (MUCG) for Claim Adjustment Group Codes (CAGC), Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC).

Claims Adjustment Reason Codes (CARC) Remittance Advice Remark Code (RARC)

Claim Adjustment Group Codes assign financial responsibility for the unpaid portion of the claim balance. A Claim Adjustment Group Code must always be used in conjunction with a CARC.

CARCs provide an overall explanation for the financial adjustment and may be supplemented with the addition of more specific explanation using RARCs.

RARC's provide additional explanation for an adjustment already described by a (CARC) or to convey information about remittance processing. There are two types of RARCs, supplemental and informational. Supplemental RARCs provide additional explanation for an adjustment already described by a CARC. Informational RARCs are referred to as Alerts and are all prefaced with Alert. Alerts are used to convey general information about the remittance processing and are never related to a specific adjustment or CARC.

A copy of the Payment/Advice MUCG can be found at <https://www.health.state.mn.us/facilities/ehealth/auc/guides/index.html>.

CAQH-CORE maintains and regularly updates their code combinations on their website at: <https://www.caqh.org/core/ongoing-maintenance-core-code-combinations>.

A full list of Group, CARC and RARC Codes can be found at <https://x12.org/reference>

Questions and Answers 7. How can I identify adjustments in the remittance?

Adjustments can occur at the claim, service line. They will appear as claim transaction showing a reversal of the original charge, payment, and adjustment amounts, along with a Claim Status code of 22 "reversal of previous payment" in the CLP02, Claim Level 2100 Loop. The corrected claim will follow in a new claim segment.

8. What is a Forward Balance (FB)?**Forward Balance**

When refunds from reversals and corrections exceed the claim payments resulting in a negative balance, Forward Balance (FB) processing is applied. The Provider Adjustment (PLB) Segment allows the negative balance from the current remit to be moved into a future remit.

- PLB (PLB03-1) Adjustment Code: FB
- PLB (PLB03-2) Adjustment Identifier: Trace number used in TRN02 of the current transaction
- PLB (PLB04) Adjustment Amount: Negative amount

835 Example: PLB^1234567890^20201231^

FB>C00000000^-86.55

Prior Balance

When overpayment recovery is initiated in a prior remittance but could not be completed because the recovery amount exceeded the paid amount for the prior remittance, the provider's overpayment balance is carried forward from the prior payment to the current payment.

- PLB (PLB03-1) Adjustment Code: FB
- PLB (PLB03-2) Adjustment Identifier: Trace number from the predecessor remit FB.
- PLB (PLB04) Adjustment Amount: Positive amount

835 Example: PLB^1234567890^20201231^

FB>C00000000^86.43

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**Questions and Answers
(continued)****9. What if there is a claim on my remittance for a subscriber that is not ours?**

Request an adjustment by contacting provider services. Please **do not** return Blue Cross' payment check or send Blue Cross a refund check unless Blue Cross requests it.

10. Why does the check I received not match the amount listed under Net Payment Activity on the statement?

Less Prior Credit Balances and Less Current Credit Balances will be subtracted from the Net Payment Amount. The provider's check should match the amount listed in the Payment Due field on the statement.

11. What can I bill the subscriber and how can I identify it on the statement?

Claim Adjustment Group Codes located on the 835 Electronic Remittance Advice (ERA) assigns financial responsibility for the unpaid portion of the claim balance e.g., PR (Patient Responsibility). This is the amount that the subscriber is responsible to pay.

12. What do I have to write off and how can I identify it on the statement?

The Claim Adjustment Reason Code in CAS Segment with Group Code CO (Contractual Obligation) signifies a provider's contractual obligation. Any amounts associated to the use of this Group Code should be written off.

13. Do subscribers receive their *Explanation of Health Care Benefits* (EOB) at the same time as providers?

No, claims that are processed during the week are bundled and only EOBs with patient's responsibility greater than a copay are printed and mailed to subscribers each Saturday. All subscriber EOBs are created and exist on Blue Cross member portal and can be printed at home or can be requested by contacting Provider Services.

All EOBs for Medicare Advantage claims and adjusted claims are printed and mailed to subscribers.

Questions and Answers (continued) 14. **How do I request an adjustment or inquiry?**

An adjustment should be requested when the provider notices the adjudication error. Please remember that if data on the claim needs to be changed, the provider must send a complete replacement claim rather than request an adjustment.

Providers can request an adjustment by:

- Fax in the *Provider Services Inquiry fax* form to:
(651) 662-2745
- Mail in a request to:
Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

For inquiries:

- Call BLUELINE at **(651) 662-5200** or **1-800-262-0820**
- Call provider services at **(651) 662-5200** or **1-800-262-0820**. Please wait 30 days before checking the status of a claim or adjustment.

**Questions and Answers 15. What do I do with interest payments?
(continued)**

Interest payments that the provider receives should be posted to a miscellaneous account. This is money that is the provider's and should not be posted to the account of the subscriber it pertains to. By posting this money to a subscriber's account they may end up with a credit.

16. Are there any limits for making adjustments?

Blue Cross may make, and providers may request, corrective claim adjustments (recoupments or additional payments) to previously processed claims for services within six (6) months from last remittance date. Blue Cross has the right to make, and Provider has the right to request, corrective adjustments to any previous payment for a claim for Health Services provided, however, that any corrective adjustments by Blue Cross, or requests for corrective adjustments by Provider that are approved by Blue Cross, shall be made within twelve (12) months from the date the claim for such Health Services was paid or denied by Blue Cross unless the adjustment is made for the following circumstances (and thus are not limited to this 12-month period):

- One or more insurer is involved, whether primary or secondary (that is, Medicare secondary payer, no-fault automobile coverage, subrogation, coordination of benefits, workers' compensation, TEFRA, etc.)
- The adjustment is required due to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.
- The adjustment is required pursuant to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.
or
- The adjustment is required as part of a contractual settlement obligation with the provider.
- Note that provider errors or data changes require a replacement claim or cancel claim be submitted within six months of the last adjudication date.
- Corrective adjustment requests must be received within 12 months from the date the claim was last paid or denied by Blue Cross.

Note: In the event Blue Cross requires medical records or an audit to finalize the amount of any corrective adjustment, Blue Cross shall notify the provider of the intent to pursue a corrective adjustment within 12 months of the date a claim is paid or denied and include a request for relevant

medical records or notification of an audit. Failure of the provider to timely provide such medical records shall not limit Blue Cross' ability to pursue any such corrective adjustments. The 12-month time frame allotted for BC to determine any adjustments shall be extended by the time period it takes for providers to provide requested medical records or information. For example, if Blue Cross notifies a provider on January 1, 2021 that it intends to pursue a corrective adjustment on claims from the time period January 1, 2020 through January 1, 2021 and requires medical records to confirm the amount owed, and provider fails to provide the medical records until July 1, 2021, this shall not limit Blue Cross' ability to pursue a corrective adjustment for the time period of January 1, 2020 through January 1, 2021, provided that Blue Cross shall be required to complete any audit of such medical records promptly following receipt of such medical records.

Remit Balancing Tips

The amounts reported in the 835 Electronic Remittance Advice, if present, must balance at three different levels; the service line, the claim, and the transaction.

Service Line Balancing

Although the service payment information is situational, it is required for all professional claims or anytime payment adjustments are related to specific lines from the original submitted claim. When used, the submitted service lines minus the sum of all monetary adjustments must equal the amount paid for the service line.

- $\text{Charge} - \text{Adjustment Amount} = \text{Payment Amount}$

Claim Balancing

Balancing must occur at the claim level so that the submitted charges minus the sum of all monetary adjustments equals the claim paid amount.

- $\text{Charge} - \text{Adjustment Amount} = \text{Claim Payment Amount}$

Remit Balancing

Within the transaction, the sum of all payments minus the sum of all adjustments, through use of the Claim Adjustment and Service Adjustment Segments, CAS, or Provider Level Adjustment Segments, PLB, decrease the payment when the adjustment amount is Positive, and increase the payment when the adjustment amount is negative.

- $\text{Sum of all Payments totaled} - \text{the Sum of all Adjustments} = \text{Total payment amount of this remittance}$

Chapter 10

Appeals

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Provider Appeals

Introduction

Providers are eligible to appeal:

- Post service claim denials
- Prior authorization and Admission Notification denials

For information regarding settlement appeals, refer to your provider agreement.

For information regarding submission of replacement or cancel claims, refer to Chapter 8 in this manual.

Instructions for the submission of appeals are listed in this chapter.

Please read the information carefully to ensure your appeal is reaching the appropriate area within Blue Cross and Blue Shield of Minnesota (Blue Cross) as that will allow for an efficient and timely review of your request.

Post Service Claim Appeals

A post service claim appeal is a written request for the review of a processed claim.

The Minnesota Uniform Companion Guides, version 6.0, dated February 19, 2013, Section 3.2.3, define an appeal as “Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.”

Submitting a Post-Service Appeal

A post service claim appeal must be requested within 90 days of the claim’s remittance. There is no limit on the dollar amount for an initial appeal.

A standard claim appeal submitted with a completed AUC appeal form and attached supporting documentation will be completed within 60 days of receipt. The appeal decision is final unless the charges in question exceed \$500.00. At that time, a voluntary second level review is available. Providers may submit a post service claim appeal related to their provider liability under one of the following categories:

- Timely filing denial
- Payer allowance
- Incorrect benefit applied
- Eligibility issues
- Coding issues
- Benefit Accumulation Errors
- Medical Policy/Medical Necessity

Post-service claim appeals should be submitted using the Availity Appeal Submission Portal. The Portal allows for the submission of supporting documentation including items such as chart notes, medical records, operative reports and letters of medical necessity. Both the patient’s name and date of service must be included on each page of the documentation submitted to assure the documentation is specific to the patient and corresponds to the dates of service.

Providers should include appeal information for only one subscriber per Portal submission. If providers are appealing their liability on multiple claims for the same subscriber, all claims should be submitted using one Portal transaction.

Note: Appeals for BlueCard claims cannot be submitted using the Availity Appeal Submission Portal and must be submitted by fax or mail.

Post Service Claim Appeals (continued)

If the Portal is not accessible, providers may default to submitting their appeals via fax or mail.

Mailing address and fax number (Commercial, Medicare, CCStpa, BlueLink TPA):

Blue Cross and Blue Shield of Minnesota
Attn: Provider Appeals
PO Box 982800
El Paso, TX 79998-2800
Fax: (651) 662-2745

Mailing address and fax number (Medicaid, MNCare, MSHO)

Blue Cross and Blue Shield of Minnesota
Attn: Provider Appeals
PO Box 982816
El Paso, TX 79998-2805
Fax: (651) 662-6288

AUC Forms

All post service claim appeals related to provider liability amounts, regardless of submission method, must be submitted on the Minnesota Administrative Uniformity Committee (AUC) Appeal Request Form along with all necessary and supporting documentation required on the form. When submitting an appeal on the Portal, the information required on the AUC form is entered in the application and supporting documentation is uploaded. The AUC form can be accessed at:

[AUC Best Practice Appeals Form - Fillable \(state.mn.us\)](https://state.mn.us)

The AUC form must include a specific and comprehensive explanation of the reason for the appeal. This explanation must include patient name, patient member ID, claim number(s), dates of service (s) and a specific detail(s) about what is being appealed and why it should be overturned. All pertinent medical records should be submitted at the time of appeal.

Appealing on Behalf of a Subscriber

Providers appealing member liability on behalf of a subscriber must include written authorization from the subscriber. Authorization requests for a Platinum Blue or Medicare Advantage subscriber require an Appointment of Representative (AOR) form, available at:

[CMS-1696](#)

Post Service Claim Appeals (continued)

All other lines of business require an Authorization for Disclosure of Health Information (ADHI) form, available at:

[X21006R07 ADHI Jan 2020.pdf \(bluecrossmn.com\)](#)

Appealing a Claim Denial for No Prior Authorization

If a provider does not obtain a required prior authorization (PA) before rendering services, Blue Cross will deny claims as provider liability for lack of PA. This denial will not be eligible for a medical necessity appeal, and an appeal should not be submitted. Blue Cross allows an administrative appeal to be submitted for limited situations listed below. These appeals must be submitted within 90 days of the claim notification issuance date and must be supported by submitted documentation:

- Blue Cross is the subscriber's secondary coverage and PA is not required (e.g. Medicare is primary).
- Another insurance company is identified as the payer and a claim was submitted to the other payer within the timely filing guidelines with Blue Cross subsequently identified as the patient's primary coverage.
- The patient is identified as the payer and is billed for the service, but later the patient reports Blue Cross coverage for the date of service. Appeals for this exception must include notes about accounts receivable actions. For example, include notes documenting calls with the Blue Cross Service Center or notes that the subscriber was sent to collections within 120 days after date of service.
- The subscriber was enrolled in the plan retrospectively, after the service was provided.
- A previously prior-authorized service unexpectedly changed for medically necessary reasons, or it was determined that an unforeseen additional service was necessary.
- Extenuating circumstances beyond the control of the rendering provider or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g. natural disaster or Availability outage).

Voluntary Second Appeal

Voluntary Second Appeals must be submitted by fax, mail or via the Availity Appeals Portal within 60 days of the notification upholding the decision of the initial appeal. To be eligible for a voluntary second appeal, the amount at issue must be \$500.00 or more. Calculate the amount at issue by subtracting the deductible, coinsurance, and paid amount from the billed charge.

For example:

Billed amount	\$2,000.00
(deductible)	500.00
(coinsurance)	200.00
(paid amount)	500.00
Amount at issue	\$ 800.00

If the amount in question is \$500.00 or more then this appeal review may be conducted by the Appeals & Grievances Team as well as Integrated Health Management.

Claims for the same patient or multiple patients relating to the same category can be aggregated at this level (you may combine two or more claims to meet the \$500.00 amount-in-controversy requirement).

Voluntary second appeals must be submitted with additional information over and above what was submitted with the initial appeal. These requests must also be submitted on an AUC Appeal form and should note “**Secondary Appeal**” on the form.

**Prior authorization
Appeal Process**

Providers may appeal a prior authorization request denied as not meeting medical necessity guidelines. The request may be initiated by letter or telephone. Written requests should be addressed to the Appeals & Grievances Team using the address or fax number provided in the denial letter. An appeal reviewer will review the case and make a final determination.

Providers may appeal a denied prior authorization request within 30 days of notification. The request must be in writing.

Mailing address and fax number (Commercial, Medicare, CCStpa, BlueLink TPA):

Blue Cross and Blue Shield of Minnesota
Attn: Appeals and Grievances
PO Box 982800
El Paso, TX 79998-2800
Fax: (651) 662-9517

Mailing address and fax number (Medicaid, MNCare, MSHO)

Blue Cross and Blue Shield of Minnesota
Attn: Appeals and Grievances
PO Box 982816
El Paso, TX 79998-2805
Fax: (651) 662-6287

When coverage is denied for Prior Authorization based on medical necessity, Blue Cross notifies the provider by telephone and/or sends letters to the member, hospital, and physician. The physician, member or facility may appeal the denial. The appeal may be initiated either by letter or by telephone.

Blue Cross' review is only a medical necessity review and is subject to all other limitations in the member's contract. Services may be denied because of exclusions, limitations on preexisting conditions, and medical necessity requirements contained in the member's contract. These contract provisions will prevail over a medical necessity decision. The decision to continue an inpatient stay or services ultimately rests with the patient and the physician.

During the appeal process, all available information is provided to a physician reviewer who is board certified in the same or similar general specialty as typically manages the medical condition or treatment and was not involved in the original determination.

Urgent/Expedited Appeals

An urgent appeal is done when an initial or continued treatment is dependent on a quick determination. Urgent is defined as medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, although it may not rise to the level of being a life-threatening circumstance, or
2. In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals are completed within 72 hours of receipt of the appeal request, or sooner, based on the medical exigencies of the case. Providers should contact the Blue Cross clinician who signed the denial letter to initiate an urgent appeal.

BlueCard® Appeals

Appeals for BlueCard claims are handled through Blue Cross.

Generally, providers will follow the same appeal process. If coordination is required with the member's Plan, Blue Cross will coordinate it. Appeals for timely filing of BlueCard claims must be submitted to the patient's Blue Plan.

BlueCard Appeal vs. Adjustments

BlueCard requires that for the following circumstances, new claims must be submitted. Adjustments /appeals cannot be reviewed in these instances:

- Change an incorrect Individual Provider NPI
- Change an incorrect member ID number, including alpha prefix
- Claim was sent in for a patient that is not yours
- Claims that are returned to the provider with either a yellow or green form attached

Appealing Claims Processed by the Member's Plan

Appeals for claims processed by the member's plan are handled by the local plan. Minnesota Blue Cross will work with the member's plan to facilitate the request. Providers should send a completed AUC Appeal Form and the applicable attachments to Blue Cross as instructed.

Supporting Documentation

Both the patient’s name and date of service should be included on **each page** of the documentation submitted to assure the documentation is specific to the patient and corresponds to the dates of service at issue.

The list below includes common types of claim denials that may be submitted for appeal and the sources of documentation suggested for each type. This information is presented as a guide to assist you and is not a complete listing.

Type of Denial or Reduction	Documentation
Surgical Complications	Operative report, chart notes, letter stating rationale for complication
Medical Necessity	Medical records and rationale for service performed
Investigative	Medical records and rationale for service performed
Cosmetic	Medical records and rationale for services
DRG/Category Code	Rationale for questioning of payment
Private Room	Notes, doctor’s order, and letter of medical necessity
Allowed Amount for unlisted codes	Chart notes or invoice, NDC number and a letter to review allowance for an unlisted code. This is independent from medical necessity review process. Note: An invoice is required for DME or supply allowance appeals.
Allowed Amount – for modified CPT/HCPCS codes.	Chart notes, letter, and operative report when applicable to review allowance.
Allowed Amount – excluding unlisted codes.	Copy of fee schedule or provider agreement.

**Supporting
Documentation
(continued)**

Type of Denial or Reduction	Documentation
Incompatible Diagnosis	Letter requesting review of codes that are denying as incompatible and related notes
Timely Filing	<p>Timely filing is addressed in Chapter 8.</p> <p>Documentation supporting submission of a claim after timely filing, such as secondary coverage, patient expired during timely filing period, or DME rental charges that span the timely filing period.</p>

Signature requirements

Complete and appropriate provider signatures are required. The provider's appeal may be denied if the following are not found on the documentation:

- Practitioner legible* handwritten signature or a unique electronic identifier (“e.g., electronically signed by”)

*Illegible handwritten signatures will be rejected unless there is a signature log sent with the appeal or is on file

- Provider credentials
- Date and time signed

Stamped signatures are not allowed.

Utilization Review Decision Appeal

Under current external review provisions, Provider or any other authorized representative may initiate an external review appeal on behalf of a Subscriber, with the express written authorization of said Subscriber. Provider and Blue Cross agree that this appeal process is binding, unless the Subscriber initiates an external appeal related to Utilization Review decisions. If a Subscriber, a duly authorized representative of the Subscriber, or a Provider initiates an appeal related to Utilization Review decisions, Blue Cross shall abide by all applicable external review requirements of Minnesota Statutes, Section 62Q.73.

Arbitration

Timeline to Commence Arbitration	<p>The Parties agree that any disputes or controversies relating to payment for Health Services shall be commenced no later than two years from the date of the provision of said Health Services by Provider (provided that such time limit shall not apply to those circumstances where claims adjustments are not limited to 12 months, as set forth in the Provider Policy & Procedure Manual). If the source of a dispute or controversy does not in any respect involve a payment for a Health Service, then such action must be commenced within two years of the date on which Provider's claim arose. Any action not brought within the time limits set forth above shall be barred, without regard to any other limitations period set forth by law or statute.</p>
Venue/Applicable Law	<p>All arbitrations between the Parties shall be venued in Minneapolis, Minnesota and shall be conducted in accordance with Minnesota law and, except to the extent inconsistent with Minnesota law, the Commercial Arbitration Rules of the American Arbitration Association. If any of the Parties are defendants to a claim which is not subject to mandatory arbitration, including, without limitation, claims involving medical malpractice, then that Party may assert indemnity or contribution claims against any other Party within the non-arbitrable action.</p>
Emergency Services	<p>In accordance with the CAA requirements for emergency services, effective January 1, 2022, Blue Cross and Provider, will have four days to successfully negotiate payment after a claim for emergency services is paid or denied by Blue Cross. If payment is not successfully negotiated, determination of out-of-network rates to be paid by Blue Cross shall be determined through an independent dispute resolution (IDR) process.</p>

<p>Process to Invoke Arbitration</p>	<p>A Party may invoke arbitration by serving written notice on the other Party. The notice will include a list of arbitrator candidates. If the Parties agree on one of the arbitrator candidates in the notice, then the arbitrator will serve as the sole arbitrator of the dispute. If the Parties do not agree on an arbitrator within fifteen (15) calendar days after receipt of the notice, the recipient of the notice will select one arbitrator and the Party providing notice will select one arbitrator within ten (10) calendar days thereafter and the two arbitrators so selected will select a third arbitrator within ten (10) calendar days thereafter. The third arbitrator so selected will be the sole arbitrator and will conduct the arbitration.</p> <p>All disputes between the Parties will be separately arbitrated and will not be joined or combined with the arbitration or other resolution of disputes between Blue Cross and any other person(s) or class of persons, unless expressly agreed to by the Parties in writing. Notwithstanding the above, and except for medical necessity reviews as detailed in Minnesota statute 62M, the Parties further agree that any appeals decision involving Medical Necessity or provider credentialing for which arbitration is pursued will be overturned or modified only if the arbitrator determines that the decision of the appeals panel or reviewer was arbitrary and capricious. Nothing in this mandatory arbitration provision shall provide a right of arbitration where such rights have been waived or another review process has been agreed to.</p>
<p>Arbitration Expenses/Award</p>	<p>Each Party will be responsible for payment of its own attorneys or other advisors and for its appointed arbitrator. The expenses and fees of the sole arbitrator and of the arbitration proceeding will be shared equally by each of the Parties. The Parties will abide by and perform any award rendered by the arbitrators and a judgment of the court having jurisdiction in accordance with this Agreement may be entered on the award.</p>

Chapter 11

Coding Policies and Guidelines

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Introduction

Purpose

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, CDT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policies, Reimbursement Policies, and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential, if appropriate, and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

Overview

Blue Cross and Blue Shield of Minnesota (Blue Cross) requires submission of valid codes to report medical services, medical dental services and supplies on both professional and institutional claims. This includes Healthcare Common Procedural Coding System (HCPCS) codes, Current Procedural Terminology (CPT), International Classification of Diseases 10th Revision, Current Dental Terminology (CDT), Clinical Modification (ICD-10-CM) diagnosis and procedure codes, and Revenue codes. If the code is not valid on the date submitted, the claim will be returned or denied.

All nationally developed codes are accepted; however, coverage is not guaranteed, and other restrictions may apply. Services may deny for various reasons, including but not limited to a subscriber contract exclusion or service limitation, a Blue Cross reimbursement, or medical policy, or standardized coding edits.

Compatibility

Procedure and Diagnosis Codes

Blue Cross requires that diagnosis codes and procedures performed be compatible. These conditions are identified separately not only to assure correct coding, but also to appropriately apply benefits. For example, maternity related procedures should be linked to maternity related diagnoses.

Revenue Codes

Revenue codes must also be compatible with the type of facility, place of service, and type of claim. On the 837 institutional claim, this is the claim facility type code and claim frequency code. Some revenue codes are very specific to the place where the service was rendered.

For example, the TOB 0111 indicates an original claim for a hospital inpatient admission through discharge.

Preventive Care Services

Preventive care services to prevent illness, disease or other health problems before symptoms occur are covered according to a predefined schedule based on certain risk factors. These include, but are not limited to, recommendations of the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control, the Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP) and Minnesota mandates. The frequency and eligibility of services is subject to change. For more information about preventive care services, go to [Preventive Care | Blue Cross MN](#) or call Provider Service.

Executive Physicals are not covered as health plan benefits unless an employer group has an add-on benefit. While there is some overlap in the types of services, Executive Physicals include non-standard annual preventive care services benefits

General Guides

- Submit the code that most accurately identifies the service(s) performed. Documentation in the patient’s medical record must support the codes submitted.
 - Do not use multiple codes when services can be represented by a single code, unless otherwise instructed. Fragmented services (reporting several codes when one adequately defines the service) will be subject to our coding software edits and may be denied.
 - Unlisted codes should only be used if no code exists to describe the service or supply. Procedure codes for unlisted services require a complete narrative description.
 - Submit all services for the same date of service on the same claim. Blue Cross will allow zero-billing or no-charge claim lines.
 - “C” HCPCS codes.
 - Codes **C1000-C9999** are for items classified in new-technology ambulatory payment classifications (APCs) under the outpatient prospective payment systems.
 - It is the intention of CMS to allow the use of the codes by all payers regardless of payment methodology, so C HCPCS codes will be accepted on institutional (UB-04 or 837I) claims only. However, C codes submitted on a professional claim (CMS HICF/837P), other than freestanding ambulatory surgical centers (ASC), will deny as provider liability.
 - "D" CDT codes
 - CDT codes represent dental services and should be reported when there is a CDT code that is specific for the service rendered.
 - CPT codes should not be billed when a CDT code represents the dental service being performed.
 - Services covered under a member’s Dental plan should not be submitted to medical coverage. Verify benefits with a member’s dental coverage before submitting to medical insurance.
-

Coding Edits

Overview

Blue Cross uses code edits for all medical products to help expedite and improve the accuracy of processing claims. Unbundling, fragmentation, mutually exclusive procedures, duplicate, obsolete or invalid codes are all identified using these coding edits. The procedure code edits are based on CPT guidelines, a review of the Center for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) policies and guidelines, Minnesota Administrative Uniformity Committee (AUC), specialty society guidelines, and agreed upon industry practices. This automated review process is designed to consistently apply the same industry criteria to all claims.

Diagnosis Code Sequencing

Primary/first listed diagnosis codes must be assigned according to the coding and sequencing instructions published in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and the accompanying ICD-10-CM Official Guidelines for Coding and Reporting. Blue Cross and Blue Shield of Minnesota (Blue Cross) follows these guidelines and will not reimburse claims that have been submitted with an inappropriate primary/first listed diagnosis code.

Coding Appeals

Blue Cross' coding edits are updated at minimum annually, to incorporate new codes, code definition changes, and edit rule changes. All claims submitted after the implementation date of this update, regardless of service date, will be processed according to the updated version. Where Medicare's CCI (Correct Coding Initiative) edits are identical, we will consider the appeal with additional documentation, but the issue may be upheld. No retrospective payment changes, adjustments, and/or request refunds will be made when processing changes are a result of new code editing rules due to a software version update.

Blue Cross has adopted a standard process to review code edit appeals and providers have the right to appeal with additional information. If you have a question or appeal about our policy regarding a particular coding combination, provide a written statement of the concern, along with the following information and/or documentation normally required for a medical review.

- Written explanation supporting the procedures submitted, for example, specific references, specialty specific criteria
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted

Once received, the inquiry or appeal will be reviewed and if necessary, forwarded to the medical review department for determination. The review may result in approval or denial of the claim, based on review of the information submitted

Note: Requests to add modifiers 24, 25, 57, 59, XE, XP, XS, XU to a denied service must follow the replacement claim process. Replacement claims submitted without medical records will be denied and the original claims will remain as originally processed.

Refer to *Chapter 10* for additional information regarding submission of appeals.

Reimbursement Policy

Overview

Blue Cross and Blue Shield of Minnesota has developed reimbursement policies to provide general guidance on payment methodologies for medical, surgical, and behavioral health services. Coding and reimbursement processes are subject to all terms of the Provider Service Agreement, as well as changes, updates, and other requirements for coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, CDT, ICD-10-CM), only codes valid for the date of service will be accepted.

All Reimbursement Policies can be found on the Blue Cross website. The link to the Reimbursement Policy section on the Blue Cross website is:

www.bluecrossmn.com/providers/reimbursement-policies

Claims Audits

Audit of Hospital Inpatient Claims

Facility billing guidelines for the UB-04 claim form (CMS-1450) / institutional 837I require providers to bill revenue codes to describe services provided. Because revenue codes do not describe exact items, supplies and services provided during an inpatient hospitalization, a post payment audit involving the examination of an itemized bill and associated medical records may be conducted to verify that services are not unbundled, fragmented, or otherwise duplicative of another charge billed for the same patient on the same day.

The following are examples of inpatient services, supplies and equipment that are considered to be included in room and board or the charges for other services or procedures, and therefore not separately reimbursable. This is not an all-inclusive list:

- Routine services, supplies, equipment/items that are included within the overall room and board or room care charges - including dietary services, nursing services, minor medical and surgical supplies, wall or canister oxygen and compressed air, oximetry, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not applicable. This includes equipment that is rented by the hospital.
- Specialized services provided by nursing staff, that are included in the daily critical care unit charge (e.g., intensive care/coronary care/intensive care neonatal units) including, but not limited to: respiratory therapy, intensive care nursing, PICC line, ventilator support management/maintenance, respiration and cardiac monitoring equipment, cardiac defibrillators etc.
- Supplies, items, and services that are necessary or otherwise integral to the provision of a specific surgery, procedure, or service, and/or the delivery of services in a specific location (e.g., treatment room, endoscopy lab, cardiac cath lab, pulmonary and cardiology procedural rooms).
- Floor stock that is generally available to all patients receiving services including:
 - Items/supplies that may be purchased over the counter.
 - All reusable items, supplies and equipment that are provided to all patients during an inpatient admission, including a treatment area or unit.
 - All reusable items, supplies and equipment are provided to all patients receiving the same service.

Note: Health care providers (facilities, physicians, and other health care professionals) are expected to exercise independent medical judgment in providing care to patients. This content is not intended to impact care decisions or medical practice.

**Audit of
Hospital
Inpatient
Claims
(continued)**

Charges for Medical/Surgical Supplies and Devices – Implants

- Billed charges for Implants (revenue codes 0274-0276 and 0278) may require a vendor's invoice to support supplies used that correspond to the services rendered unless otherwise agreed upon.
- These units must be clearly indicated on the vendor invoices submitted with the claim. If the units do not match or are not noted, the revenue code for Implant may be denied unless otherwise agreed upon.
- If supplies are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice or the revenue code for Implant may be denied unless otherwise agreed upon.

**Inpatient
Hospital
Readmission
Review**

Inpatient hospital readmission reviews will be conducted for all Blue Cross and Blue Shield of Minnesota (Blue Cross) lines of business, with the exception of Platinum Blue.

Same Day and Planned Readmissions

The following types of readmissions will be reviewed to determine eligibility for reimbursement, as specified in the Blue Cross reimbursement policy, Facility 003 - Inpatient Hospital Readmission:

- Readmission on same calendar day as discharge
- Planned readmission/leave of absence

Unplanned Readmissions

Unplanned readmissions on post-discharge calendar days 1-30 (Commercial/Medicare Advantage) or 1-15 (Medicaid) will be clinically reviewed consistent with the direction provided in the Medicare Quality Improvement Organization (QIO) Manual, Chapter 4, Section 4240, to determine if the readmission was:

- Medically unnecessary or
- Clinically related to the initial admission and
- Preventable – A readmission is deemed preventable if it is reasonably likely that inpatient hospital admission could have been prevented if the patient had received care consistent with accepted standards during the prior hospitalization and post-discharge follow-up period. Examples of preventability could include, but are not limited to, acquired complications, lack of stability or return to baseline at discharge, failure to complete medication reconciliation, or patient/caregiver education in self-care, and lack of timely follow-up care.

Medically unnecessary and/or preventable readmissions will be denied.

Note: Intervening admissions to non-acute care facilities (e.g., a skilled nursing facility) do not impact the designation of an admission as a readmission.

**Inpatient
Hospital
Readmission
Review
(continued)****Exclusions/Exemptions**

The following types of care are exempt from readmission review:

- Neonatal care
- Obstetrical care
- Ophthalmologic emergency
- Sickle cell crisis
- Cancer or immunotherapy treatment
- Transplant and transplant-related care
- Hospice care
- The treatment of a mental health disorder as the primary reason for the admission
- Discharged from the hospital against medical advice
- Rehabilitation
- A principal or secondary diagnosis of COVID-19

Chapter 12

Pharmacy Services

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Pharmacy Services

Claims Submission

Pharmacy Claims for Blue Cross Subscribers without a Pharmacy Benefit Manager

All pharmacies that are contracted with Blue Cross and Blue Shield of Minnesota (Blue Cross) are required to submit prescription charges on behalf of any Blue Cross subscriber, when a subscriber's contract does not use a pharmacy benefit manager. The pharmacy should not request that the subscriber pay for any services before claim adjudication other than the copayment amount stated on the subscriber's Subscriber ID card. At this time the pharmacy claims should be submitted in a paper format. Once the claim is received at Blue Cross, the appropriate benefits and reimbursement will be applied according to the provider and subscriber contracts.

Claims Filing Requirements

Most of our Subscriber contracts contain basic drug coverage. Drug claims are either processed by Blue Cross or Prime Therapeutics. To determine if a drug claim should be submitted to Blue Cross or Prime Therapeutics for processing, check the Subscriber's ID card. If the Subscriber has drug processing through Prime Therapeutics, the medical identification (ID) card will indicate RxPCN (the carrier code) "PGIGN" or "HMSH" for migrated subscribers. A Prime Therapeutics provider must be used. You must include the two-digit numeric dependent code, which is indicated before the name on the Subscriber ID card. For an example of a Subscriber ID card, refer to bluecrossmn.com. Type in the search field "sample id card."

Drug Claims Submission

Providers within the Prime Therapeutic network must submit claims electronically. If the Subscriber has Prime Therapeutics coverage, but the Prime Therapeutics information is not printed on the Subscriber ID card, the Subscriber should pay the prescription in full and submit the claim to Prime Therapeutics for direct reimbursement.

Submit Prime Therapeutics Subscriber drug claims to:

Prime Therapeutics
Mail Route BCBSMN
P.O. Box 25136
Lehigh Valley, PA 18002-5136

Prescribing Physician's NPI

The physician's NPI (National Provider Identifier) number must be entered on all electronic or paper claims submitted for payment. This information is used for drug utilization review aimed at improving the quality of health care delivered to our Subscribers. Leaving this data element out or use of a dummy NPI number constitutes an incomplete pharmacy claim.

Prior Authorization

Expansion of Drug-related Prior Authorization Categories and Services

Blue Cross added prior authorization (PA) categories for drugs and an online PA request portal/service that is enabled with eligibility checking and electronic fax submission capability. Prior authorization requests may continue to be faxed to their review destination external to the portal. Complete a [Minnesota Uniform Form for Prescription Drug Prior Authorization \(PA\) Requests and Formulary Exceptions](#)

Prior authorization categories

PA categories and criteria can be accessed using the Blue Cross and Blue Shield of Minnesota provider link.

Access: [Resources for Health Care Providers](#)

- Under Tools and Resources, select Medical policy, then acknowledge the Acceptance statement.
- Select “+” next to “Utilization Management” scroll down the page to “Pharmacy Utilization Management” and Select.

CoverMyMeds prior authorization request service

CoverMyMeds (CMM) is a free service to providers, which allows quick and easy submission of PA requests for various drug plans. Experience with CMM by other plans has demonstrated marked reductions in physician office call-backs regarding PA requests, after CMM is implemented.

You may access CMM at covermymeds.com. Select Help (top right of the web page) to view FAQs and Support tutorials, which describe how to get started (3-5 minutes). You may choose to set up an account within CMM, to familiarize yourself with the features. After opening your account, there are three easy steps for using CMM:

- **Find the right PA form** – Enter the state, drug, and Blue Cross drug plan and click Start request. The appropriate PA forms will display.
- **Share the PA form (optional step)** – Begin to populate the PA form then use the system to fax or email the form to another health care provider for completion.
- **Submit the PA form** – Upon completion of the form, the PA can be printed, signed, and faxed, or the physician can sign it digitally and submit it via the CMM fax feature.

Injectable Drugs

Most prescription benefit plans allow injectable drug claim processing online. Be sure to use the appropriate NDC and submit your claim electronically to the processor.

**Pharmacies
Submitting
Claims for DME**

For durable medical equipment, the pharmacy must follow the normal process for claims submission utilizing the electronic 837P claim format.

The Aware Agreement, Article III, Section A, "Scope of Services" states: "Provider shall provide Health Services to Subscribers for eligible Prescription Drugs which are authorized by a valid prescription." This section also includes the dispensing of durable medical equipment (DME) to Blue Cross subscribers.

It is the responsibility of the participating pharmacy to submit the claims for all such eligible services to Blue Cross on behalf of the subscriber. After the claim is processed by Blue Cross, you will be notified of the proper amount to bill the subscriber, if any balance remains due from the subscriber.

It is also the responsibility of all participating providers to abide by all other terms and provisions of the agreement including, but not limited to, the administration of the coordination of benefits provisions. This process is detailed in Article III, Section M, Coordination of Benefits.

Claim Processing

NDC Numbers	The NDC numbers submitted on the pharmacy claim must be taken from the container from which the drug was dispensed. The NDC number must match the manufacturer and package size.
Copays/Coinsurance	The drug copay/coinsurance amount varies for each subscriber. Rely on “claim response” to correctly identify the amount to collect from the Subscriber. If a Subscriber’s contract contains the formulary amendment, a dual copay may be in effect. Again, rely on “claim response” to determine the correct amount to collect from the Subscriber.
Vacation Prescription Requests	Requests for additional drug quantities may be made by the Subscriber, physician, or pharmacist. The Subscriber would contact the customer service number listed on the back of their Subscriber ID card. The physician or pharmacist would contact the pharmacy help desk. Please keep in mind that some drugs are controlled substances that may have different treatment than non-controlled substances.
Prescription Cost Less Than Copay	If the cost of the prescription is less than a Subscriber’s copay, the Subscriber should pay the lesser of the allowed amount as shown on the claims response.
Discounting or Waiving Copays	In order to maintain the level of subscriber responsibility specified in Blue Cross contracts, it is essential that Subscribers pay the agreed-upon copay for preferred and non-preferred drugs. Both Subscriber and provider agreements specifically state that the copay must be collected in full. Noncompliance of this provision, through discount or waiver, could result in termination of the provider agreement.
Pharmacy Audits	Blue Cross performs comprehensive pharmacy program integrity audits to ensure compliance with its programs.

Drugs

Drug Formulary

Blue Cross promotes the use of the Subscriber's specified drug formulary. The formularies have been developed to provide a listing of drugs that are safe, effective, high-quality and economical.

- **BCBSMN FlexRx:** This is the formulary for Blue Cross' PPO and other commercial business. This formulary provides Subscribers broad access to medications at a reasonable cost that utilizes both brand and generic drugs.
- **BCBSMN GenRx:** This is a formulary for some commercial business. This formulary consists mostly of generic drugs. Brand drugs are on the formulary only when a generic drug is not available to treat a specific medical condition or when the brand drug offers a significant advantage over generic drugs.
- **BCBSMN BasicRx Individual (Non-Grandfathered):** This is a formulary with an effective drug list that is designed to lower the cost of care with drug and category level exclusions. This formulary is compliant with the benchmark formulary requirements of the Affordable Care Act and is used in business lines where such compliance is required.
- **BSBSMN KeyRx:** This is a formulary for the commercial business. It is a formulary with an effective drug list that is designed to lower the cost of care with drug and category level exclusions.
- **BCBSMN GenRx Small Group (HSA-Blue Print-Blue Connect):** This is a formulary certified compliant with the benchmark formulary requirements of the Affordable Care Act and it is used in business lines where such compliance is required.
- **BSBSMN Medicaid GenRx:** This is the formulary for Medicaid.
- **Platinum Blue:** This is the formulary for Medicare-Platinum Blue.
- **Secure Blue:** This is the formulary for Medicare-Secure Blue.
- **Ideal:** This is the formulary for Medicare Advantage.

**Drug Formulary
(continued)****Definitions:**

- Formulary is a list of preferred drugs with coverage under the plan. This list may change during the year.
- Preferred drug is a drug that is covered under the plan because it is included on the formulary drug list.
- Non-preferred drug is a drug not on the formulary drug list but could be covered under an open pharmacy benefit plan design.
- Open pharmacy benefit plan design is a benefit design that covers most drugs regardless of the status (preferred or non-preferred) on the formulary drug list. The Subscriber's financial responsibility will vary based on formulary status and benefit design.
- Closed pharmacy benefit plan design is a benefit design that covers only drugs on the formulary drug list. A Subscriber can get a non-preferred drug but is responsible for 100 percent of the cost unless a formulary exception is submitted and approved.

Requesting to add a drug to the formulary:

Any participating health care provider may request the addition of a non-preferred drug to a preferred status by sending a letter to Blue Cross. Include the following:

- Name of prescribing MD
- Clinic name
- Clinic phone number
- Clinic fax number
- Name of drug
- Name of manufacturer
- Rationale for adding the drug

A new FDA-approved drug is not considered to be on the drug formulary until it has been approved by the formulary committee. To view the formularies, go to: [Prescription Drugs](#), select "Search a Drug List".

**Drugs with a
Non-Preferred
Status**

Physicians may request coverage of a non-preferred drug for a Subscriber by completing the [Minnesota Uniform Form for Prescription Drug Prior Authorization \(PA\) Requests and Formulary Exceptions](#). Subscriber liability for non-preferred drugs is subject to the Subscriber specific benefit design.

**Quantity Limits,
Prior
Authorization,
and Step Therapy**

Blue Cross has implemented programs to help subscribers to use drugs safely and to make sure drugs prescribed by a provider are used correctly. The following programs are currently utilized by Blue Cross.

Prior Authorization: Blue Cross requires prior authorization for selected drugs (the list of drugs requiring prior authorization is available on the Blue Cross member/subscriber website and provider links). Providers or subscribers may initiate a prior authorization request from the Blue Cross website, by phone, fax, electronically or in writing.

Step Therapy: In some cases, Blue Cross requires a subscriber to first try certain drugs as a prerequisite to using a brand name drug in the same category.

Quantity Limits: For certain drugs, Blue Cross limits the amount of the drug that will be paid by Blue Cross at one time.

Substitutions/Interchanges: Blue Cross' formularies are designed to promote generic prescribing and utilization of generic drugs by subscribers, such that generic substitution or therapeutic interchange programs are seldom, if ever implemented. Minnesota State Laws determine how generic substitution and therapeutic interchange may be delivered at the point of sale. In general, a generic version of a brand name drug may be dispensed if in a pharmacist's professional judgment, the less expensive generically available drug is safely interchangeable with the prescribed brand.

Drug list and request form

FlexRx Standard Prior Authorization, Quantity Limit and Step Therapy Drug List (PDF) – The list is subject to change without notice.

1. Access [Blue Cross Health, Dental and Vision Plans](#)
2. To locate the document hit “See prescription drugs information”
3. Hit “search a drug list”
4. Select BCBS Minnesota and on the dropdown menu select “not a Medicare Part D Member”
5. Select BCBS MN FlexRx Drug List and find document titled “Utilization Management Summary”.

**Quantity Limits,
Prior
Authorization,
and Step Therapy
(continued)**

GenRx Standard Prior Authorization, Quantity Limit and Step Therapy Drug List t (PDF) – The list is subject to change without notice.

1. Access [Blue Cross Health, Dental and Vision Plans](#)
2. To locate the document hit “See prescription drugs information”
3. Hit “search a drug list”
4. Select BCBS Minnesota and on the dropdown menu select “not a Medicare Part D Member”
5. Select BCBS MN GenRx Drug List and find document titled “Utilization Management Summary”

Coverage Exception form can be found at www.myprime.com.

The prescriber can also get this form by calling provider services at **(651) 662-5200** or **1-800-262-0820**.

The prescriber must complete and submit a coverage exception form to request a quantity limit exception, prior authorization, or step therapy exception.

**Compounded
Prescriptions**

Use of the compound indicator for compounded prescriptions is reserved for prescriptions requiring the pharmacist to combine two or more ingredients.

**Dispense As
Written (DAW)**

Blue Cross provides for the payment of claims coded “dispense as written” (DAW). Consistent with state law, DAW must be in the physician’s handwriting or when an oral prescription is given, specifically stated. Physicians may use DAW to prevent generic substitution. Only a physician may indicate DAW on a prescription. Neither Subscriber nor pharmacist may change this status for any reason. A DAW may not always result in a lower copay. This will be dependent on the subscriber’s benefit plan.

**Investigative
Drug Use**

Drugs used investigatively are not eligible for reimbursement.

Drug Programs

Specialty Drugs

Specialty drugs are used to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. They are typically injectable and can be self-administered by a subscriber.

When a Subscriber receives their drugs from a specialty network supplier, they are assured quality while saving money and time. Contact provider services to verify if the subscriber's plan has the specialty drug program as an available benefit.

Quality

The specialty network supplier are experts in supplying drugs and services to patients with complex health conditions.

Convenience

The Subscriber can order their specialty drug each month from a specialty drug supplier, pay their health plan's applicable in-network copay or coinsurance amount and eliminate the expense of driving or having to find transportation to a pharmacy to pick up their drugs.

Specialty Drug List

The Specialty Drug List is available at on www.myprime.com.

Other prescription drugs

Only select injectable and oral drugs are available through the specialty drug program. Subscribers will need to continue to get their other prescription drugs through their local pharmacy.

More information

Additional information is available on bluecrossmn.com in regard to the specialty drug network.

**Specialty Drugs
(continued)****Specialty Network Suppliers**

The specialty drug benefit program offers you these choices in professional specialty drug suppliers:

- **Fairview Specialty Pharmacy, LLC**
1-800-595-7140
(612) 672-5262 (Fax)
www.fairviewspecialtyrx.org
- **AllianceRx Walgreens Prime**
1-877-627-6337
1-877-828-3939 (Fax)
<https://www.alliancerxwp.com/>
- **Children's Home Care***
1-866-656-1020
(612)-813-7207 (Fax)

*Children's Home Care can only fill prescriptions for Hemophilia medications.

The specialty network suppliers were selected for their outstanding customer service and dedication to patients. These suppliers are experts in handling the types of drugs you're taking.

AllianceRx Walgreens Prime is an independent company providing central specialty and mail service pharmacies.

Fairview Specialty Pharmacy, LLC is an independent pharmacy providing specialty medications.

Medication Therapy Management

Medication Therapy Management (MTM)

Blue Cross and Blue Shield of Minnesota offer medical and MTM pharmacy contracts. Blue Cross' pharmacy MTM program provides services for commercial, FEP, Medicaid and Medicare Part D populations. There are specific MTM requirements from CMS (Center for Medicaid and Medicare) for the Part D population.

MTM Program Description and Objectives

MTM services are an interactive person-to-person, telephonic, or telehealth medication review and consultation conducted in real-time between a member and/or another authorized representative, such as the caregiver or prescriber, and a pharmacist. Pharmacist will ensure each member's medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the member as intended. The pharmacist will develop a prioritized list of medication related problems and create a plan to resolve with the member, caregiver to the member, and/or the member's prescriber.

MTM services are designed to increase members' knowledge of their prescriptions, over the counter (OTC) medications, herbal therapies, and dietary supplements. It is also designed to help members identify and address problems or concerns related to their medications and empower them to self-manage their medications and health conditions. The objectives for the MTM program include improved quality of care provided to the member and an increased understanding by the member of the medications they are prescribed.

A Comprehensive Medication Review (CMR) is a systematic process of collecting member-specific information, assessing medication therapies and medical conditions to identify medication-related problems, (MTPs) and creating a plan to resolve the medication therapy problems with the member, caregiver to the member, and/or the member's prescriber.

A Targeted Medication Review (TMR) is any visit in a calendar year after the completion of a CMR. A TMR is conducted to follow up on medication-therapy problems identified during a CMR with the goal of resolving the medication therapy problems. TMRs can also be conducted if a member has additional questions regarding their medication therapy after a CMR (i.e., a TMR cannot be provided prior to the completion of a CMR visit during the calendar year with the member for any line of business).

CMR and TMR are member-specific and individualized services provided directly by a pharmacist for the individual member. Member education information, such as medication counseling related to the dispensing of a prescription or other population-focused activities do not meet the definition of a CMR or TMR by themselves.

**Provider
Expectations**

Providers (pharmacists) in the Blue Cross MTM network are expected to provide services that align with the Patient Centered Primary Care Collaborative definition of Comprehensive Medication Management

<https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf>

The provider's role is to prevent, identify, and resolve medication related problems based upon individual member's preferences, goals, and needs. Importantly, Blue Cross expects that all contracted MTM providers take responsibility for assuring optimal medication related outcomes for our members.

The patient care process consists of the following basic elements:

1. Performing assessments of the member's health status for each medical condition and medication.
2. Evaluating the member's response to therapy (assessment of medications) for appropriateness.
 - a. What are the member's understandings, expectations, experiences, and concerns with their medication therapy?
 - b. Is each medication indicated, effective, safe, and convenient based on the member's medical conditions? Can the member remember to take their medication as intended to enhance medication adherence?
3. Identifying, resolving, and preventing medication-related problems (MTPs). This includes creating a plan to follow up with the member to resolve any identified MTP's
4. Documenting the care delivered and communicating essential information to the member's primary care providers or other care team members to support coordination of care.
5. Providing education designed to enhance the member's understanding and appropriate use of medications.

To support the achievement of member's optimal medication related outcomes, MTM providers are expected to collaborate with others on the member's health care team. Reasonable actions must be taken to acquire relevant clinical and lab information related to the medication use for individual members from their care providers.

Documentation Requirements

1. The pharmacist conducting the CMR/TMR visit must document all required elements outlined below in an electronic medical record (EMR).
 - Name and NPI (National Provider Identifier) of pharmacist conducting the visit
 - Recipient of CMR/TMR (member, member's prescriber, caregiver, other authorized individual) If not member, the name and relationship to member must be included {i.e., Tammy Johnson, RN (Registered Nurse) assisted living}
 - Member's legal first and last name
 - Address and telephone number
 - Date of Birth
 - Date of encounter/visit
 - Reason for the visit/chief complaint
 - Cognitive Status
 - Method of Assessment - office, phone, in-person, telehealth
 - Social history - smoking, caffeine, alcohol use, if taken at time of visit but not mandatory
 - Allergies to medications or adverse effects (if available)
 - Current medication list including prescriptions, over the counter and supplements
 - Indication and medical condition associated with each medication the member is taking, including how they are taking each medication
 - Medication therapy problems (MTP) identified
 - The status of each MTP, (e.g., resolved by prescriber, waiting for prescriber response,) as well as the medical condition and medication with which the MTP is associated
 - MTPs resolved (For Medicare Part D members, only the MTPs identified and resolved in the calendar year should be reported back to Blue Cross)
 - Plan for resolving medication therapy problems and for follow up
 - What communication is being provided to the member's primary care provider(s)

- Relevant objective clinic findings (i.e., lab results, blood pressure results of physical exam)
 - Member's next steps or to-do list
 - Date the CMS Standardized Letter was sent (for CMR only for Medicare Part D members)
 - a. This is specific for the Medicare Part D population. The provider shall print and mail the required CMS standardized member take-away documents within 14 calendar days following the completion of the CMR. Such member take-away documents must follow the CMS standards.
2. Providers must submit a CCD (Continuity of Care Document) file to Blue Cross via secure file transfer SFTP (Secure File Transfer Protocol) by the 10th business day of each month
 - a. CCD files are only required for the Medicare Part D population at this time.
 3. Provider shall abide by the CCD file format technical specifications per the Medicare Part D addendum. The provider must also be able to provide copies of the visit notes and takeaway documents to Blue Cross within 72 business hours of a request for such information. This is part of the standard audit process to ensure members are receiving a consistent experience and that documentation matches the level of services.

CCD Expectations

Providers shall abide by the CCD file format in accordance with CMS rules and standards for Medicare Part D members and Blue Cross Medicare addendum. The CCD file must be sent to BlueCross every 30 days by the 10th business day of the month. If a CCD file is not submitted with the required specifications, an error file will be generated and automatically sent to the provider. It is expected that the errors will be corrected, and the updated CCD file sent with the following month's CCD file submission.

Member Opt Out Requirements for Medicare Part D

Members who are eligible for MTM services may choose to opt-out of the program. A decision to Opt Out must be documented and reported to Blue Cross at least every 30 days. Opt Out decisions must be made by the member or Power of Attorney. Refusing an individual service for any reason or lack of responsiveness does not automatically disenroll the member from future MTM services. This means that a member must Opt Out of the CMR and automated/quarterly TMR to Opt Out of the MTM program.

Documentation of member opt-outs from the MTM program is required. It must include that a conversation occurred between the Provider and the Member which includes communication of the details noted in the below example. The following explanation, or something materially similar, may be utilized by the Provider when communicating the option for the Member to elect to not participate in the MTM program.

MTM Program Explanation: Medicare recommends a visit with a pharmacist to review your medications each year. This is called a comprehensive medication review (CMR) and is included in your Blue Cross Medicare Part D Prescription Plan at no cost to you. A pharmacist will review all your medicines with you, both prescription and over the counter, to make sure your medicines are safe, affordable, and working well for you. Your pharmacist will also answer any questions that you have about why you are taking each of the medications. After the visit, your pharmacist will mail you a personalized medication list and a recommended to-do list that you can keep for your records. Additionally, your pharmacist may contact you periodically if any medication-related concerns are identified with your medications based on your prescription history. You do not have to participate in the MTM program, and whether you choose to participate will not affect your coverage or benefits. What time of the day would be best for you to have a pharmacist review your medicines?

If the Member responds with “No” to CMR: remind them of the benefits of receiving an annual review of their medications. If they are still not interested in the CMR, offer the Member Automated Targeted Medication Review (TMR) (see below)

Automated TMR should be offered as follows: The MTM program also provides Automated Targeted Medication Reviews where Blue Cross may reach out to you if a medication concern is identified based on your prescription history. Would you like Blue Cross to contact you for this medication review?

Member Opt Out Requirements for Medicare Part D (continued)

If Member responds to “No” for Automated TMR: We will note that on your file and not contact you for the rest of this year for the MTM program. As a reminder, you can always call us back if you have any medication related questions or concerns.

- Member should be marked as **“Opt Out”** since they declined both the CMR and Automated TMR
- Inform the Member that they may be re-eligible for MTM services each year and ask if they want to be contacted in future years.
 - If they respond no, document Member as **“Permanently Opt Out”**.

If Member responds to “Yes” for Automated TMR: We will continue to provide automated targeted medication reviews for the remainder of the year. If you change your mind and would like a comprehensive review as well, feel free to call back any time this year.

- The medical record should include the detail that the Member **“declined CMR, accepted automated TMR.”**

Audits

BlueCross reserves the right to a detailed review and audit of data and information to ensure members receive a consistent experience with MTM services and to confirm documentation aligns with the requirements set forth by CMS for the Medicare Part D population. Note that the documentation standards and patient care process apply to all lines of business. Data validation and audits shall be supported through access to records, reporting, clinical information, data, and other information as necessary to demonstrate a consistent and impactful experience for all members.

Clinical information includes but is not limited to:

- Documentation of pharmacist's subjective, including reason for visit if member Opted-In for services
- Objective information
- Assessment of medications reviewed
- Assessment of conditions reviewed and the status of each medical condition
- Medication-therapy problems identified (MTPs)
- Medication therapy problems resolved
- Plan to follow up, if appropriate to resolve medication-therapy problems identified during the CMR or TMR.

Provider shall make available to Blue Cross, within 72 business hours, all information listed and supply a copy of the member take-away documents and outreach attempts, if applicable to the provider.

Billing Process

Blue Cross will reimburse providers only for a completed CMR or TMRs (face-to-face, telephone, telehealth) with the member or their authorized representative.

Provider shall request reimbursement for MTM services via claim submission for all product types/lines of business, including Commercial, FEP, Medicaid, and Medicare Part D. Provider shall promptly submit claims in accordance with all claims submission rules and Blue Cross shall settle such claims for CMR and TMRs.

Of note, there is a three visit MTM limitation per member per provider per year for the Commercial (Fully Insured) population.

Providers should submit the number of units based on the amount of time spent with the member. This aligns with the AMA (American Medical Association) definition of CPT codes. This should only include time spent with the members for each visit and does not include additional time spent documenting the encounter.

Claims will be submitted for CMR and TMRs with the following CPT codes:

CPT Code	Definition
99605	<p>A first encounter service performed with a member in a time increment of up to 15 minutes (used for comprehensive medication review). One 99605 is allowed per provider, per calendar year for all lines of business.</p> <p>Disclaimer: Medicaid members will be reimbursed for one 99605 per provider per calendar year (1/1-12/31). Rolling 365-day calendar year does not apply.</p>
99606	<p>Used with an established member, who has had an initial visit in the calendar year, in a time increment of up to 15 minutes for a subsequent or follow-up encounter (used for targeted medication review). 99606 can only be submitted for members who have had a 99605 submitted in the same calendar year for the same plan.</p> <p>There is a limit of up to seven units of 99606 per member per provider per year for Medicaid plan only.</p>
99607	<p>Additional increments of 15 minutes of time for 99605 or 99606. Reimbursement will be limited to 3 units of 99607 per visit for all lines of business.</p>

Questions? If you have questions, please contact provider services at (651) 662-5105 or 1-800-262-0820 or via email at: MTM.Pharmacy@bluecrossmn.com.

Chapter 13

Minnesota Health Care Programs

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Minnesota Health Care Programs

Public Health Nursing Services

The following services may be billed by Public Health on a professional claim (837P). Public Health may bill for Enhanced Services for “At-Risk” Pregnancies, as well as patient education services found in Chapter 10 of the MHCP manual.

Codes	Description
H1001	“At-risk” Antepartum Management
H1002	Care coordination
H1003	Prenatal health education I Prenatal health education II Prenatal nutrition education services
H1004	Postpartum follow-up home visit
S9442	Birth classes, non-physician provider, per session
S9443	Lactation classes, non-physician provider, per session
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session
S9446	Patient education, not otherwise classified, non-physician provider, group, per session

Interpretive Services

Blue Plus contracts with interpreter agencies to provide sign and spoken interpreter services for subscribers of Blue Plus MHCP plans only.

These subscribers can be identified by their identification numbers, which begin with Alpha Prefix MQG or MQS. Blue Plus requires providers to perform their own direct billing for interpreter services (with some exceptions, noted below).

Providers are welcome to utilize any agency that they choose, in-house or contracted agency or the services of any qualified interpreter at the clinic. Any interpreter services provided to Blue Plus MHCP subscribers must be rendered by an interpreter registered and rostered on the Minnesota Department of Health (MDH) website with proper certification.

Providers may use individual interpreters or may also establish a relationship with an interpreter agency. Providers must submit the claim for the interpreter services. Blue Plus will reimburse the Provider for the interpreter services provided at their site. The Provider pays the interpreter or agency directly. The arrangement between the Provider and the interpreter or agency is independent of Blue Plus.

**Interpretive
Services,
continued**

Services provided by interpreters who do not meet the qualifications outlined in the statute are ineligible for payment and should not be billed to Blue Plus. Interpreters who are not properly qualified cannot bill either Blue Plus or the subscriber.

Claims submitted with charges for interpreter services that do not have a medical or dental claim associated with the charges are subject to recoupment.

Hospitals are responsible for arranging and reimbursing interpreter services for hospital inpatient services.

Interpreter services are not separately reimbursable in a facility place of service, whether inpatient or outpatient, as the interpreter services are included in the facility's reimbursement.

Clinic based interpreter – If a primary care clinic or other health care provider has interpreter services available the subscriber must use the clinic's interpreter services.

Personal Care Assistant (PCA) agencies that are contracted with Blue Plus are required to provide culturally appropriate services to Limited English Proficiency subscribers. Individual PCA's are required to speak the same language as the subscriber to whom they provide care. Interpreter services are not a covered service when billed separately in association with PCA Services.

The only exception for direct billing to Blue Plus is:

- Dental
- Contracted County Social Service and Public Health
- Blue Plus Care Coordination Delegates
- Home Health Agencies (Non-Behavioral Health)

These providers must use a contracted Interpreter Agency. The Interpreter Agency will bill Blue Plus directly for eligible services.

**Interpretive
Services,
(continued)****Billing Guides**

The following guides for reporting interpreter services have been approved by the MN Administrative Uniform Committee and are listed in the MHCP Provider Manual under Access Services.

Note: Rounding rules apply to all services. A minimum of eight minutes must be spent in order to report one unit.

Code	Modifier	Description
T1013		Face-to-face spoken language interpreter service
T1013	U3	Face-to-face sign language interpreter service
T1013	GT	Telemedicine interpreter service via interactive audio and video telecommunications systems
T1013	U4	Interpreter service provided via telephone, smartphone, tablet or other similar processes. Does not include delivery of telemedicine interpreter service
T1013	UN UP UQ UR US	2 members served 3 members served 4 members served 5 members served 6 or more members served Do not use modifier 52 to denote multiple members in a group setting
*D9990		*Dental Services Providers Only: for sign or spoken interpreter services, bill one unit per visit using code D9990. This is a covered benefit for both children and pregnant women and non-pregnant adults.

**Interpretive
Services,
(continued)**

Ineligible Interpreter Services:

- Translating documents (paper to paper)
- Community health workers (CHW) – included in CHW service rates
- Day treatment & habilitation (DT&H) providers – included in the DT&H rate
- ICF/DDs (Intermediate Care Facility/Developmental Disability) – included in the facility rate
- Indian Health Service (IHS) for federally funded encounter rate recipients – included in the encounter rate
- Inpatient hospitals – included in the inpatient hospital DRG payment
- Nursing facilities – included in the per diem rate
- Transportation providers – the service of transporting a patient does not include interpreter service reimbursements
- No shows or cancellations
- Interpreter's mileage, parking fees, meals, wait time or travel time
- Voicemail services, and weekend or after-hours premium fees

Blue Plus Contracted Interpreter Agencies

Provider	Details
<p>Bridge World Language Center Inc</p>	<p>Phone: 320-259-9239</p> <p>Email: mini@bridgelanguage.com</p> <p>Website: https://www.bridgelanguage.com</p> <p>Service Area (By County):</p> <p>Anoka, Benton, Clay, Dakota, Hennepin, Ramsey, Sherburne, Stearns. Additional counties can be covered virtually.</p> <p>Virtually and in-person</p> <p>Languages Provided:</p> <p>Arabic, Cambodian, Farsi, French, Hindi, Korean, Kurdish, Laotian, Pashto, Russian, Somali, Spanish, Swahili, Tagalog, Turkish Ukrainian, Urdu, Vietnamese</p>
<p>Claro Interpreting Services LLC</p>	<p>Phone: 651-705-8890</p> <p>Email: twila@claro-is.com</p> <p>Website: N/A</p> <p>Service Area (By County):</p> <p>Anoka, Benton, Blue Earth, Carver, Dakota, Hennepin, Kandiyohi, Le Sueur, Morrison, Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright</p> <p>In-Person, virtually by request</p> <p>Languages Provided:</p> <p>Amharic, Arabic, Armenian, Burmese, French, Karen, Kiswahili, Oromo, Romanian, Russian, Somali, Spanish, Swahili, Thai, Ukrainian, Vietnamese</p>

Provider	Details
<p>Dialog One LLC</p>	<p>Phone: Interpreter Service Line 651-379-8550</p> <p>Email: customercare@dialog-one.com</p> <p>Website: www.dialog-one.com</p> <p>Service Area (By County):</p> <p>Statewide on-demand phone/video interpreter access only.</p> <p>note: if you do not already have access to Dialog One’s services, please reach out to your Blue Plus contact.</p> <p>Languages Provided:</p> <p>Amharic, Anuak, Arabic, Bosnian, Bulgarian, Cambodian, Chinese (Cantonese and Mandarin), Egyptian (Arabic), Ewe, Farsi, French Creole, French, German, Hindi, Hmong, Karen, Kirundi, Korean, Lao, Moroccan (Arabic), Oromo (Oromia), Polish, Portuguese (Brazil), Romanian, Russian, Somali, Spanish, Sudanese (Arabic), Swahili, Tibetan, Tigrinya, Turkish, Ukrainian, Vietnamese, Pashto, Dari and other major languages and dialects.</p>

Provider	Details
<p>FAJ Language Services LLC</p>	<p>Phone: 612-412-2197</p> <p>Email: Fajlanguageservices@gmail.com</p> <p>Website: https://faj.agency/</p> <p>Service Area (By County):</p> <p>Kandiyohi</p> <p>Languages Provided:</p> <p>English, Somali, Spanish, Karen and Swahili</p>
<p>INGCO International</p>	<p>Phone: 612-605-8006</p> <p>Email: sales@ingcointernational.com</p> <p>Website: https://ingcointernational.com</p> <p>Service Area (By County):</p> <p>Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Le Sueur, Mille Lacs, Pierce, Ramsey, Scott, Sherburne, St. Croix, Washington, Wright, Other counties and out-of-state available. Please inquire.</p> <p>Virtually and in-person</p> <p>Languages Provided:</p> <p>Common: Amharic, Arabic, Russian, Somali, Spanish, Korean, Portuguese</p> <p>Must be requested 72 hours prior to assignment: Oromo, Vietnamese, French, Hmong, Ukrainian</p> <p>Video Remote or Over the Phone only: Chinese (Mandarin), Lao, Korean, Nepali, Thai, Tagalog, Tigrinya, Swahili</p>

Provider	Details
Itasca Interpretation Services	<p>Phone: 651-457-7400</p> <p>Email: avang@itasca.biz</p> <p>Website: www.itascacorp.biz</p> <p>Service Area (By County):</p> <p>Face-To-Face: Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, and Washington</p> <p>Anoka County, Dakota County, Hennepin County, Olmsted County, Ramsey County, Washington County, Winona County</p> <p>Telehealth Only: Goodhue County, Lincoln County, Lyon County, Murray County, Redwood County, Rice County, Stearns County, Wright County.</p> <p>In-Person and virtual</p> <p>Languages Provided:</p> <p>Amharic, Arabic, Bassa, Burmese, Chinese – Mandarin, Farsi, Tagalog (Filipino), French, Hmong, Italian, Karen, Karenni Korean, Kru, Laotian, Nepali, Oromo, Pidgin English, Portuguese, Russian, Somali, Spanish, Swahili, Thai, Tigrinya, Ukrainian, Vietnamese, Yoruba. Cambodian, Cantonese, Taiwanese, German, Hindi</p>
KY Interpreting Services Inc	<p>Phone: 218-393-3504</p> <p>Email: kyinterp@gmail.com</p> <p>Website: N/A</p> <p>Service Area (By County):</p> <p>MN-Saint Louis, Lake, Cook, Carlton, Pine, Aitkin, Itasca, Crow Wing.</p> <p>Languages Provided:</p> <p>ASL/English, only</p>
Language Incorporated	<p>Phone: 507-573-1427</p> <p>Email: info@languageincorporated.com</p> <p>Website: www.languageincorporated.com</p> <p>Service Area (By County):</p> <p>Steele, Rice, Waseca, Ramsey, Mower, Freeborn & Blue Earth</p> <p>In-Person & Phone Services.</p> <p>Languages Provided:</p> <p>Arabic, Spanish, Somali, Thai, Swahili, Vietnamese, Karen, Hmong, Anuak, Nuer</p>

Provider	Details
<p>LinguaOne Inc</p>	<p>Phone: 507-351-8787</p> <p>Email: tessa@linguaone.com</p> <p>Website: www.linguaone.com</p> <p>Service Area (By County): Steele, Waseca, Rice, Ramsey, Olmsted, and Blue Earth, all the other counties would be virtually.</p> <p>Languages Provided: Arabic, Somali, Spanish, Anuak, Nuer and Swahili.</p>
<p>Minnesota Interpreters and Translators (MINT)</p>	<p>Phone: 510-858-6468</p> <p>Email: services@mintlanguages.com</p> <p>Website: https://mintlanguages.com</p> <p>Service Area (By County): Translating services throughout Minnesota, eastern North Dakota, and Western Wisconsin Virtually-MINTNOW, and in-person</p> <p>Languages Provided: NA.</p>
<p>Open End Communication</p>	<p>Phone: 612-232-1923</p> <p>Email: openendcommunication@gmail.com</p> <p>Website: www.openendcommunication.com</p> <p>Service Area (By County): Stearns County, On Site, Virtual, Telephonic</p> <p>Languages Provided: Somali, English.</p>
<p>Project Fine</p>	<p>Phone: 507-452-4100</p> <p>Email: info@ProjectFINE.org</p> <p>Website: www.projectfine.org</p> <p>Service Area (By County): Winona County (in person) Statewide (Phone/Virtual).</p> <p>Languages Provided: Arabic, Bosnian, Bulgarian, Cambodian, Cantonese, Czech, Dari, Dinka, French, Spanish, Hmong, German, Hindi, Hmong, Italian, Japanese, Korean, Laotian, Mandarin, Nepali, Pashtu, Portuguese, Russian, Somali, Spanish, Swahili, Vietnamese.</p>

Provider	Details
Speak Wise Solutions LLC	<p>Phone: 320-223-5102</p> <p>Email: Speakwisesolutions@gmail.com</p> <p>Website: N/A</p> <p>Service Area (By County): Hennepin, Stearns, Anoka, Ramsey, Sherburne.</p> <p>In-Person, phone by request</p> <p>Languages Provided: English, Arabic, Swahili, Somali, Oromo, Amharic.</p>
The Language Banc Inc	<p>Phone: 612-588-1904</p> <p>Email: info@thelanguagebanc.com</p> <p>Website: https://thelanguagebanc.com</p> <p>Service Area (By County): Metro, Stearns, and surrounding Counties, WI</p> <p>Languages Provided: Spanish, Somali, Hmong, +150 more</p>
VIDA	<p>Phone: 320-339-1131</p> <p>Email: vidainterpreting@gmail.com</p> <p>Website: www.vidainterpreting.com</p> <p>Service Area (By County): Todd, Stearns, Morrison, Wadena, Douglas, and Pope Counties.</p> <p>In-Person and virtual</p> <p>Languages Provided: Spanish - On Site</p>
West Central Interpreting Services LLC	<p>Phone: 320-235-0165</p> <p>Email: mahboub2000@gmail.com</p> <p>Website: https://wcinterpreters.com</p> <p>Service Area (By County): Kandiyohi, Stearns, Hennepin & Ramsey, 7 county metro, Swift, Chippewa, Renville, McLeod, Lyon, Wright, Otter Tail, Clay, Pope</p> <p>In-Person and virtual</p> <p>Languages Provided: Amharic, Arabic, Oromo, Karen, Kiswahili, Somali, Spanish</p>

Provider	Details
<p>3H Interpreters</p>	<p>Phone: 218-979-1377</p> <p>Email: amarh.3hinterpreters@gmail.com</p> <p>Website: https://3h-interpreters.business.site</p> <p>Service Area (By County):</p> <p>Anoka, Benton, Clay, Dakota, Hennepin, Ramsey, Sherburne, Stearns. Additional counties covered virtually.</p> <p>In-Person and virtual</p> <p>Languages Provided:</p> <p>Arabic, Basnian, Cambodian, Farsi, French, Hindi, Korean, Kurdish, Laotian, Pashto, Russian, Somali, Spanish, Swahili, Tagalog, Turkish, Ukrainian, Urdu, Vietnamese, Nepali, Mandarin, Tigrinya, Kinyarwanda, Haitian-Creole, ASL.</p>
<p>Bytesos Language & Consultancy Services LLC</p>	<p>Phone: 615-877-3523</p> <p>Email: bytesos2023@gmail.com</p> <p>Website: N/A</p> <p>Service Area (By County):</p> <p>Stearns, Hennepin, Washington, Ramsey, Faribault, Kandiyohi, Blue Earth, Nicollet & Scott.</p> <p>Languages Provided:</p> <p>Somali, English, Swahili, Amharic, and Arabic. Spanish</p>
<p>Global Language Solutions LLC</p>	<p>Phone: 612-205-5321</p> <p>Email: info@gl-solution.com</p> <p>Website: N/A</p> <p>Service Area (By County):</p> <p>Hennepin, Ramsey & Anoka.</p> <p>Languages Provided:</p> <p>Somali + 100, In Person, Telephonic</p>
<p>Metropolitan Human Resources LLC</p>	<p>Phone: 952-300-3303, 612-517-6994</p> <p>Email: info@metropolitanhumanresources.com</p> <p>Website:</p> <p>Service Area (By County):</p> <p>Hennepin, Ramsey & Anoka</p> <p>Languages Provided:</p> <p>Somali.</p>

Provider	Details
The Minnesota Language Connection, Inc	<p>Phone: 651-644-7100</p> <p>Email: candrade@minnesotalanguageconnection.com</p> <p>Website: www.minnesotalanguageconnection.com</p> <p>Service Area (By County):</p> <p>All Counties in Minnesota</p> <p>Languages Provided:</p> <p>Amharic, Anuak, Arabic, Bengali, Burmese, Cambodian, Cantonese, Dari, Creole, Farsi, French, Hindi, Hmong, Indonesian, Italian, Japanese, Karen, Karenni, Korean, Laotian, Mandarin, Nepalese, Oromo, Persian, Pushto, Portuguese, Punjabi, Russian, Serbian, Somali, Spanish, Thai, Ukrainian, Vietnamese</p>
Intercultural Mutual Assistance Association	<p>Phone: 507-289-5960</p> <p>Email: languageservices@imaa.net</p> <p>Website: www.imaa.net</p> <p>Service Area (By County):</p> <p>Southeast Minnesota (Rochester, Red Wing, Albert Lea area) South Central Minnesota (Mankato area)</p> <p>Languages Provided:</p> <p>Amharic, Anuak, Arabic, Dari, Dinka, Farsi, French, Hindi, Hmong, Juba Sudanese, Khmer, Laotian, Mandarin, Oromo, Pashtu, Quechua, Somali, Spanish, Swahili, Vietnamese</p>
Prairie Interpreting Services Inc.	<p>Phone: 952-836-2795</p> <p>Email: Service@prairieinterpreting.com or adam@prairieinterpreting.com</p> <p>Website: https://www.prairieinterpreting.com</p> <p>Service Area (By County):</p> <p>7 Metro counties, Kandiyohi, Olmsted, Rice, Sterns & St. Louis Kandiyohi, Olmsted, Sterns & St. Louis</p> <p>Languages Provided:</p> <p>Amharic, Arabic, Bengali, English, Farsi, Italian, Khmer, Oromo, Somali, Sudanese, Swahili</p>

Community Health Workers

Blue Plus may reimburse for certain educational services provided by Community Health Workers (CHWs).

Practitioner Enrollment Process

- A CHW must meet Minnesota Department of Human Services (DHS) eligibility requirements and be enrolled through DHS before requesting enrollment with Blue Plus. DHS requirements are outlined in the MHCP Manual, which can be found at [Community Health Worker \(CHW\) \(state.mn.us\)](http://state.mn.us).
- Upon receiving a Unique Minnesota Provider Identifier (UMPI) number from DHS, a CHW may then request to be registered with Blue Plus. This process may be initiated by completing the Individual Practitioner Addition and Termination Form, which can be accessed at bluecrossmn.com. The CHW must be registered with Blue Plus before services can be billed.

Subscriber and Service Eligibility

Subscribers enrolled in the following Blue Plus plans will have benefits for services rendered by a CHW:

Blue Plus Plan	Alpha Prefix
Blue Advantage (Families and Children)	MQG
MinnesotaCare	MQG
Minnesota Senior Care +	MQG
SecureBlueSM (HMO SNP)	MQS

**Community
Health Workers
(continued)**

- To be considered eligible for reimbursement, educational services provided by a CHW must be rendered face to face in a clinic, outpatient or home setting and be related to a medical diagnosis. In addition, the services must be supervised by a Blue Cross and Blue Shield of Minnesota (Blue Cross) or Blue Plus eligible physician, dentist, public health nurse, mental health professional, or advanced practice registered nurse (APRN).
- Reference the MHCP Provider Manual for additional information regarding requirements for physician orders/care plans, medical record documentation, record keeping and curriculum as they relate to CHWs. This communication can be found at [Community Health Worker \(CHW\) \(state.mn.us\)](http://state.mn.us)

Billing

CHW services should be billed to Blue Plus as follows:

- Claims format: Professional (837P)
- Codes: 98960, 98961, 98962, D1206 or 99188
- Provider Number: Enter the Blue Plus individual provider number or UMPI number of the CHW on each service line
- Diagnosis: Enter a valid ICD-9-CM or ICD-10-CM diagnosis(es) on the claim and link to the appropriate service line

Reimbursement

Blue Plus will utilize our standard Minnesota Health Care Programs pricing methodology for reimbursement of CHW services.

**Hearing Aid Fee
Schedule Update**

Blue Plus uses the MHCP Hearing Aid Volume Purchase Contract (which contains the MHCP Hearing Aid Contract) as the base Medical Assistance Fee Schedule. Blue Plus will follow the non-covered code list contained in the MHCP Hearing Aid Contract and the DHS supply limits.

Products Affected

The following MHCP products are affected:

- Blue Advantage (Families and Children & MSC+)
- MinnesotaCare
- SecureBlue

MHCP Hearing Aid Volume Purchase Contract

The hearing aid service provider must dispense the hearing aid according to the hearing aid exam, selection and prescription of the otolaryngologist and audiologist.

For accurate claims processing, the provider will need to submit an attachment that includes the manufacturers' specifications. Providers should utilize the information contained in the current MHCP contracts, including manufacturer, model name and model number. This information must be included in the attachment when the claim for reimbursement is submitted. Blue Plus will verify that the hearing aid billed is a covered benefit for the subscriber and will apply the current MHCP Hearing Aid Volume Purchase Contract pricing for reimbursement. Items not included in this pricing will defer to the DHS Medical Assistance standard fee schedule or the Blue Plus standard fee schedule, as applicable.

Website

The current MHCP Contract Pricing can be found at:

[Hearing Aid Contract, Vendors, Models, Prices and Codes / Minnesota Department of Human Services \(mn.gov\)](#)

Hearing Aid Fee Schedule Update (continued)

Prior authorization

If the subscriber requires a hearing aid that is not listed on the DHS Volume Hearing Aid Purchase Contract or the subscriber needs a replacement prior to the five-year expected usage of their current hearing aid, a prior authorization may be submitted for review of coverage to the prior authorization fax line as follows:

- Blue Advantage Families and Children/MSC+/MNCare and SecureBlue: 651-662-6284

Please include the following information in the request:

- Audiologic recommendations, including:
 - Written recommendations for hearing aid(s), including the manufacturer specifications
 - Follow-up plan for determining the effectiveness of the hearing aid
 - Audiogram or reason why this was not obtained
 - History of previous hearing aid use
 - Pure tone average
 - Reason why a standard hearing aid on the Volume Hearing Aid Purchase Contract is not appropriate for this subscriber

GenRx Formulary

The drug formulary GenRx will apply for subscribers covered under MHCP.

This formulary offers drugs that have been shown to be safe and effective, while being cost conscious. The GenRx formulary consists of almost all generics, with the exception of a few generics that were not included on the new formulary due to safety or efficacy concerns. A limited number of brand-name drugs will be on formulary to provide appropriate coverage of most disease states.

Most SecureBlue subscribers have a Medicare Part D formulary and will not be affected.

To determine which drugs are on the GenRx formulary, visit [Medicines \(myprime.com\)](https://myprime.com) to view the list of drugs available to MHCP subscribers. Providers will have the option of entering a specific medication or view the GenRX Formulary.

1. Go to [Medicines \(myprime.com\)](https://myprime.com)
2. Choose *Continue without sign in*
3. Select the health plan *BCBS Minnesota*
4. Under *Are you a Medicare Part D member*, select *No* and click *Continue*
5. Select *BCBS MN Medicaid GenRx Drug List* and click on *Apply*
6. Enter the drug name into the search field

To view the GenRx formulary in a PDF format, click on *Forms* located on the blue bar and select *Plan documents*. Under *Plan documents* click on *List of Covered Drugs*.

**Formulary
Exception
Process**

Anti-psychotic drugs

For anti-psychotic drugs prescribed to treat a diagnosed mental illness or emotional disturbance that are not on the GenRx formulary, the health care provider prescribing the drug must certify the following to Blue Cross in writing:

1. The provider has considered all equivalent drugs on the formulary and has determined that the drug prescribed will best treat the patient's condition
2. The drug must be dispensed as written (DAW)

All other Drugs

For all other drugs not on the GenRx formulary, the health care provider prescribing the drug must follow formulary exception procedures to request an exception. The health care provider prescribing the drug must do one of the following:

1. Attest that the formulary drug causes an adverse reaction in the patient
2. Attest that the formulary drug is contraindicated for the patient
3. Attest that the patient has tried and failed at least three (or as many as available, if fewer than three) formulary alternatives for the diagnosis being treated with the requested medication
4. Demonstrate in writing to Blue Cross that the provider has considered all equivalent drugs on the formulary and has determined that the drug prescribed will best treat the patient's condition

The prescriber may be required to submit medical records that support the medical necessity for the prescribed non-formulary drug.

DAW for non-formulary drugs

Prescriptions entered with a DAW for non-formulary drugs will not process at point of sale without an approved formulary exception request. Subscribers will be directed to work with their provider to determine if a formulary drug may work for them. If the provider determines that the non-formulary drug will best treat the subscriber's condition, a formulary exception request must be submitted on the subscriber's behalf and approved.

PCA Billing

Claims for Personal Care Assistant (PCA) services for members under age 65, must be submitted to the Department of Human Services (DHS).

Claims for Personal Care Assistant (PCA) services for members age 65 and older, must be submitted to Blue Plus using one date of service per claim line. PCA services may not be billed with a span of dates; each date of service must be billed separately. Any claim lines that are submitted with more than one date of service will be denied for improper format. All claim lines should have an individual PCA associated with the service.

Billing Requirements

PCA agencies are required to follow the published billing guidelines per the AUC requirements. AUC requires providers to follow billing processes as published in the MHCP Provider Manual, PCA Agency Services.

Individual PCA Enrollment

All individual QPs and PCAs must be enrolled with Blue Plus and affiliated to all PCA agencies that they provide services for. Enrollment forms submitted with incomplete information will be sent back to the provider unprocessed along with a letter requesting the missing information. Upon receipt of a complete form, the form will be processed and, if appropriate, the individual will be affiliated with the agency. Blue Cross will require individuals to submit either their assigned NPI or UMPI number on the enrollment form.

Electronic Visit Verification

PCA and Home Health Agencies must enroll in an EVV system to document that members are receiving services that are billed to Blue Plus. Providers can use the Blue Plus selected system HHAeXchange for EVV or an EVV system of their choice, that is compatible with HHAeXchange.

The EVV System will verify:

- Type of service performed
- Who received the service
- Date of service
- Location of service delivery
- Who provided the service
- When the service begins and ends

**PCA Billing
(continued)****Minnesota Health Care Programs**

ID numbers for subscribers that have coverage with MHCP are as follows:

Product Name Group	Subscriber ID Numbers
Blue Advantage (Families and Children)	ID numbers that begin with Alpha Prefix MQG Age under 65 – Submit to DHS
MinnesotaCare Expanded (Children)	ID numbers that begin with Alpha Prefix MQG Age under 65 – Submit to DHS
Minnesota Senior Care Plus (MSC+)	ID numbers that begin with Alpha Prefix MQG Age 65+)
SecureBlue	All ID numbers that begin with Alpha Prefix MQS

**Chiropractic
Services**

MHCP coverage guidelines are followed for MHCP subscribers. All services must be medically necessary for continued coverage. Blue Cross will reimburse chiropractors for covered services when billed with a diagnosis of subluxation of the spine per benefit guidelines as published in the MHCP Provider Manual. Rehabilitation services that would not result in measurable progress relative to established goals are non-covered services. The “AT” modifier distinguishes active/corrective treatment from maintenance therapy. The AT modifier should be appended to the chiropractic manipulation (98940-98943) when services are considered active/corrective treatment. The absence of the AT modifier would indicate maintenance or palliative care and is not a covered service.

**Services to
Restricted
Recipients**

Under the Minnesota Restricted Recipient Program, either DHS or Blue Plus identifies subscribers of Blue Plus MHCP who have used Medicaid services, most often prescription drugs or emergency rooms visits for non-emergent reasons, at a frequency or amount that is not medically necessary and/or who have used health care services that resulted in unnecessary costs to the program. Once identified, such recipients will be placed under the care of a primary care physician and/or other designated providers who will coordinate their care for a 24-month or a 36-month period. Although other subscribers of Blue Plus MHCP require a referral only to nonparticipating providers, all services to a restricted recipient from other than the designated primary care physician require a referral.

Restricted Recipient Program

Placement in the Restricted Recipient Program means that for a period of twenty-four (24) or thirty six (36) months of eligibility, the enrollee must obtain health care services from:

- A designated primary care provider located in the enrollee's or recipient's local trade area
- A hospital used by the primary care provider
- A designated pharmacy

**Services to
Restricted
Recipients
(continued)**

DHS and health plans have developed a universal restriction, which is put in place by either the DHS or a health plan, and stays in effect for the entire period of restriction, regardless of whether the recipient does any of the following:

- Changes MCOs
- Moves from fee-for-service to an MCO
- Moves from an MCO to fee-for-service

Designated primary care providers can verify the restricted recipient status of a subscriber through Blue Plus provider service or through MN-ITS, the Minnesota Department of Human Services (DHS) billing system, at www.mn-its.dhs.state.mn.us/login.html. Typically, a restricted recipient is restricted to one primary care physician, pharmacy and hospital. A restricted recipient may also be restricted to other designated providers or be referred by the primary care physician to other providers, if appropriate.

Claims Reimbursement

Eligible services provided to a restricted recipient will only be reimbursed when one of the following criteria is met:

- The service is provided by the recipient's primary care physician or his/her designee
- The primary care physician has made a referral to another provider
- The service is of a provider type or type of service that is not listed as restricted on the recipient's file

Additional Information

Providers may access more information about the Minnesota Restricted Recipient Program on the DHS website with the following link:

[Health Care Programs and Services \(state.mn.us\)](http://state.mn.us)

MHCP Prior authorization

MHCP coverage guidelines are followed for MHCP subscribers, when applicable. All services must be medically necessary for coverage.

Providers can quickly determine if a service or item requires prior authorization from the health plan before care is provided by entering the member group number, date of service and procedure code. The PA Look Up tool response also includes details related to the medical policy or evidence-based criteria that may apply and any special instructions related to the prior authorization process. There are two options for providers to use:

- The Prior Authorization Lookup tool is available on the Blue Cross website under Medical Management:
<https://www.bluecrossmn.com/providers/medical-management/prior-authorization-lookup-tool>
- On Availity Essentials, follow the Authorization Request process. The first step in this process allows the provider to do an “Is Authorization Required”. If an authorization is required, the provider can simply proceed to the next step to complete the process.

If an authorization is required, it is highly recommended for the provider to utilize the online process through Availity Essentials.

To assure timeliness of the review, please submit your request form at least 14 days in advance of the procedure whenever possible.

Medical Necessity Criteria

Medical policies are found at [Medical and behavioral health policies | Blue Cross MN](#). Federal and State Guidelines, including Minnesota Health Care Program (MHCP) policies, may supersede the Medical Policies, if applicable.

Coding Requirements Reminder

All coding and reimbursement is subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (for example, HCPCS, CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS), only valid codes for the date of service may be submitted or accepted.

Transportation Services**Common Carrier and Volunteer Transportation**

Blue Plus Providers have an obligation to strictly adhere to all rules and requirements as summarized in the Provider Service Agreement, the Provider Policy and Procedure Manuals, and as required by the Minnesota Department of Human Services (DHS). Blue Plus Providers must follow all documentation and billing rules in order to remain participating providers. Blue Plus will be conducting random audits to assure adherence to all requirements in order to be responsible stewards of our health care requirements for our subscribers.

Transportation Services (continued)

BlueRide handles Common Carrier Transportation requests for rides to and from medical and dental appointments with in-network providers, if the subscriber has no other means of transportation. A BlueRide representative will discuss eligibility requirements with subscribers to confirm they are eligible for transportation services. Common Carrier providers offer ambulatory transportation, which may include buses, taxis, specialized transportation services for ambulatory riders, or volunteer driver vehicles. Children ages 12 or younger must be accompanied by an adult.

The benefit is available to Blue Advantage (Families and Children, MSC+), SecureBlue and limited MNCare Subscribers.

Subscribers who need to schedule a ride to a medical or dental appointment must be directed to call BlueRide, toll free number at 1-866-340-8648 or (651)-662-8648.

BlueRide phones are answered between the hours of Monday through Friday, 8:00 a.m. - 5:00 p.m. For scheduling purposes, Common Carrier transportation requests need to be received at least two business days prior to the day the ride is needed. Some other restrictions may apply. Subscribers do have 1 Short Notice Ride (SNR) ride exception per month for urgent or emergency medical situations. The BlueRide team will handle these issues and schedule these rides.

Rides must be scheduled by the subscriber or legally authorized representative (such as a guardian with proper paperwork). The subscriber must be present to give verbal authorization to anyone acting on their behalf at the time of the call unless there is a Power of Attorney (POA) form on file and signed by the subscriber or other appropriate legal paperwork such as guardianship papers that allows the individual to act on the subscriber's behalf.

Base Rate: Blue Plus allows one base rate (transport code) for each leg of the trip.

Transportation Services (continued)

No-Load Miles (DeadHead): Medical transportation miles driven without the subscriber in the vehicle. These cannot be billed to the subscriber. Deadhead mileage may be covered on a case by case basis and must be pre-approved by BlueRide staff. Authorization must be requested prior to the non-emergency medical ride being provided. BlueRide reserves the right to work with the most cost-effective form of transportation.

Wait Times: Wait time requests are on a case by case basis and must be pre-approved by BlueRide. Wait time should be approved ahead of the ride. If wait time could not be foreseen, requests must be submitted the next business day. It is expected that wait time request will be infrequent. Wait time is not reimbursable for the first hour.

Common Carrier Codes and Units of Service

Code	Description	Amount	Unit of Service
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	30 Minutes	1 per 30 minutes
A0080	Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest	1 Mile	1per mile
A0100	Non-emergency transportation, taxi	1 Base Rate	1 per leg
A0110	Non-emergency transportation and bus, intra or inter-state carrier	1 Base Rate	1 per leg
A0120	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	1 Base Rate	1 per leg
A0170	Transportation ancillary: parking fees, tolls, other	1 unit	1 per ride Must include a narrative description

Transportation Services (continued)

Modifiers-use proper codes with the following modifiers

For DeadHead miles, use modifier TP.

The TP modifier should be used with the mileage code. The actual loaded miles should be billed as a separate line of mileage code with the approved miles. The miles will equal the units of service

HCPCS Origin/Destination Codes (for more than one modifier on the same line item, the first position indicates the origin and the second position indicates the destination):

Code	Description
D -	Diagnostic or therapeutic site other than 'P' or 'H' when these are used as origin codes
E -	Residential, domiciliary, custodial facility (other than an 1819 facility)
G -	Hospital based ESRD facility
H -	Hospital
I -	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J -	Freestanding ESRD facility
N -	Skilled nursing facility (SNF)
P -	Physician's office
QM -	Ambulance service provided under arrangement by a provider of services. Note: Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly
QN -	Ambulance service furnished directly by a provider of services. Note: Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly
R -	Residence
S -	Scene of accident or acute event
X -	Intermediate stop at physician's office on way to the hospital (destination code only)

Transportation Services (continued)**RUCA (Rural Urban Commuting Area)**

RUCA is applied by Blue Plus when the claims reflect zip codes that fall into the RUCA areas. Non-Emergency Transportation Providers are not required to apply RUCA prior to the claims submission. RUCA is applied following DHS and MN State Legislation around transportation.

Prior Approval of all scheduled rides through BlueRide

The trip confirmation number should be submitted on the authorization line in loop 2300 on the 837P. BlueRide must authorize all scheduled rides.

No Shows

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting an email to transportation.liaison@bluecrossmn.com.

No Shows must be reported to Blue Plus by the following business day. No Shows are not covered under Blue Plus. No Shows should never be billed to Blue Plus or the subscriber.

Common Carrier Transportation Trip Sheet

Common Carrier providers must maintain a common carrier transportation service trip sheet documenting each ride that is provided to eligible Minnesota Health Care Programs subscribers. The trip sheet must be complete, comprehensive and contain all required elements in the document. Trip sheet must have all required fields completed on the Department of Human Services Trip Log or Blue Plus Trip Log.

See MHCP Provider Manual – Non-Emergency Medical Transportation Services for more information:

[Transportation Services - State-Administered NEMT](#) Non-Emergency Medical Transportation Procedure Codes, Modifiers and Payment Rates:

[Transportation Services - State-Administered Transportation Procedure Codes, Modifiers and Payment Rates](#)

These provisions, along with all Provider Service Agreement requirements are subject to audit at any time by Blue Plus.

Transportation Services (continued)

Special Transportation

Blue Plus Providers have an obligation to strictly adhere to all rules and requirements as summarized in the Provider Service Agreement, the Provider Policy and Procedure Manuals, as required by the Minnesota Department of Human Services (DHS). Blue Plus Providers must follow all documentation and billing rules in order to remain participating providers. Blue Plus will be conducting random audits to assure adherence to all requirements in order to be responsible stewards of our health care requirements for our subscribers.

All Special Transportation rides must be scheduled through the BlueRide staff.

BlueRide will schedule the rides and fax/email the information to the STS providers directly with the detailed information regarding the rides. STS providers must keep all administrative and demographic information current at Blue Plus.

BlueRide can be reached at (651) 662-8648 or toll-free at 1-866-340-8648. BlueRide phones are answered between the hours of Monday through Friday, 8:00 a.m. - 5:00 p.m. Although BlueRide will occasionally schedule same-day rides depending on provider availability, at least 24 hours advance notice is required in the metro area and two business days advance notice is required for Greater Minnesota. Subscribers do have 1 Short Notice Ride (SNR) ride exception per month for urgent or emergency medical situations. The BlueRide team will handle these issues and schedule these rides.

STS providers will be notified of scheduled rides via fax/email from the BlueRide staff.

Rides must be scheduled by the subscriber or legally authorized representative (such as a guardian with proper paperwork). The subscriber must be present to give verbal authorization to anyone acting on their behalf at the time of the call unless there is a Power of Attorney (POA) form on file and signed by the subscriber or other appropriate legal paperwork such as guardianship papers that allows the individual to act on the subscriber's behalf.

Special Transportation Level of Need (LON)

Blue Plus has updated the Level of Need (LON) requirement and process for Special Transportation. MSC+ and MSHO subscribers no longer require a LON to be on file with Blue Ride.

All rides must continue to meet the criteria for special transportation services and be scheduled through BlueRide. MHCP subscribers who need to schedule a ride to an eligible medical or dental appointment should call BlueRide at (651) 662-8648 or toll free at 1-866-340-8648.

**Special
Transportation
Services
(continued)****Additional information**

Signed LON forms will be valid for one year from date of the medical provider's signature. Any LON's that are incomplete or unreadable will be considered invalid. LONs must be faxed by the STS provider to BlueRide at **(651) 662-2844** before transportation is provided.

Claims submitted for subscribers that require an LON and do not have one on file with BlueRide will not be reimbursed.

Medical providers are NOT obligated to sign a LON. The medical provider will use their professional judgment to determine if the subscriber requires special transportation and indicates that on the LON.

Special Transportation Trip Sheet

STS providers must maintain a special transportation services trip sheet documenting each ride that is provided to eligible MHCP subscribers. The completed trip sheets must be filed in the STS provider's office and available for inspection and review by Blue Plus. Trip sheet must have all required fields completed on the Department of Human Service Trip Log or the Blue Plus Trip Log.

Reimbursement

Reimbursement for services will only be allowed, and should only be billed, when the transportation is to or from a covered medical or dental service for an eligible MHCP subscriber. Some examples of covered medical services are clinic visits, therapies, eye exams, etc. Appropriate modifiers must be used when billing for services.

An eligible MHCP subscriber is defined as a subscriber who is physically or mentally impaired in a manner that keeps him/her from safely accessing and using common carrier transportation. If an eligible MHCP subscriber does not meet this definition and is in need of transportation, please refer them to BlueRide at 1-866-340-8648.

Base Rate: Blue Plus allows one base rate (transport code) for each leg of the trip.

No-Load Miles (DeadHead): Medical transportation miles driven without the subscriber in the vehicle. These cannot be billed to the subscriber. DeadHead mileage may be covered on a case by case basis and must be pre-approved by BlueRide. Authorization must be requested prior to the non-emergency medical ride being provided. BlueRide reserves the right to work with the most cost-effective form of transportation.

Wait Times: Wait time requests are on a case by case basis and must be pre-approved by BlueRide. Wait time can only be authorized by BlueRide staff. Wait time should be approved ahead of the ride. If wait time could not be foreseen, requests must be submitted the next business day. It is expected that wait time requests will be infrequent. Wait time is not reimbursable for the first hour.

**Special
Transportation
Services
(continued)**

STS Codes and Units of Service

Code	Description	Amount	Unit of Service
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments	30 Minutes	1 per 30 minutes
A0420	Transportation waiting time, non-ambulatory stretcher vehicles only	30 Minutes	1 per 30 minutes
A0130	Non-emergency transportation; wheelchair van	1 base rate	1 per leg
S0209	Non-emergency transportation; wheelchair van, mileage per mile	1 mile	1per mile
S0215	Non-emergency transportation; mileage, per mile	1 mile	1 per mile
T2001	Non-emergency transportation; patient attendant/escort	1 attendant	1
T2003	Non-emergency transportation; encounter/trip	1 base rate	1 per leg
T2005	Non-emergency transportation; non ambulatory stretcher van	1 base rate	1 per leg
T0249	Non-emergency transportation; non-ambulatory stretcher van mileage	1 mile	1 per mile
A0170	Transportation ancillary: parking fees, tolls, other	1 unit	1 per ride Must include a narrative description

**Special
Transportation
Services
(continued)**

Modifiers-use proper codes with the following modifiers

For DeadHead, use modifier TP.

The TP modifier should be used with the mileage code. The actual loaded miles should be billed as a separate line of mileage code with the approved miles. The miles will equal the units of service

HCPCS Origin/Destination Codes (for more than one modifier on the same line item, the first position indicates the origin and the second position indicates the destination):

Code	Description
D -	Diagnostic or therapeutic site other than 'P' or 'H' when these are used as origin codes
E -	Residential, domiciliary, custodial facility (other than an 1819 facility)
G -	Hospital based ESRD facility
H -	Hospital
I -	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J -	Freestanding ESRD facility
N -	Skilled nursing facility (SNF)
P -	Physician's office
QM -	Ambulance service provided under arrangement by a provider of services. 1. Note: Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly
QN -	Ambulance service furnished directly by a provider of services. 2. Note: Institutional-based providers must report the modifier with every HCPCS code to describe whether the service was provided under arrangement or directly
R -	Residence
S -	Scene of accident or acute event
X -	Intermediate stop at physician's office on way to the hospital (destination code only)

**Special
Transportation
Services
(continued)**

RUCA (Rural Urban Communiting Area)

RUCA is applied by Blue Plus when the claims reflect point of pickup zip codes that fall into the RUCA areas. Non-Emergency Transportation Providers are not required to apply RUCA prior to the claims submission. RUCA is applied following DHS and MN State Legislation around transportation.

Prior Approval of all scheduled rides through BlueRide

The trip confirmation number should be submitted on the authorization line in loop 2300 on the 837P. BlueRide must authorize all scheduled rides.

Multiple Riders

Each Blue Plus subscriber must have an approved ride authorization for the schedule ride. This includes all family members who may be riding in the same vehicle for medical appointments. This excludes escorts, who may be family members. Multiple Riders should be applicable to the highest degree possible.

No Shows

Blue Plus requires transportation providers to report all no shows to BlueRide by submitting to **transportation.liaison@bluecrossmn.com**. No Shows must be reported to Blue Plus by the following business day. No Shows are not covered under Blue Plus. No Shows should never be billed to Blue Plus or the member.

See MHCP Provider Manual – Non-Emergency Medical Transportation Services for more information:

[Transportation Services - State-Administered NEMT](#) Non-Emergency Medical Transportation Procedure Codes, Modifiers and Payment Rates:

[Transportation Services - State-Administered Transportation Procedure Codes, Modifiers and Payment Rates](#)

These provisions, along with all Provider Service Agreement requirements are subject to audit at any time by Blue Plus.

Traditional Healing Services

Blue Plus will reimburse contracted Traditional Healing Services providers for Traditional Healing Services provided to Minnesota Health Care Programs subscribers.

The Traditional Healing Services benefit will allow \$500 per subscriber per calendar year. Blue Cross will not limit the type(s) of Traditional Healing Service(s) that a member may receive.

Subscriber and Service Eligibility

Subscribers enrolled in the following Blue Plus plans will have benefits for Traditional Healing Services rendered by a Traditional Healing Services provider contracted under the Traditional Healing Services provider specialty:

Blue Plus Plan	Alpha Prefix
Blue Advantage (Families and Children)	MQG
MinnesotaCare	MQG
Minnesota Senior Care +	MQG
SecureBlue (HMO SNP)	MQS

Billing:

Until a specific procedure code is published, providers should submit claims using the unlisted code based on the instructions below:

- 99199 - requires a narrative to include “Traditional Healing” along with a brief description of the service, for example “Traditional Healing; Naming Ceremony”
- 1 unit of service per claim line
- No rendering provider information is required

Reimbursement:

Blue Cross will allow 100% of billed charge up to the subscriber’s annual \$500 benefit maximum.

- Any charges in excess of \$500 per subscriber per calendar year will deny as provider liability unless a valid waiver is signed and on file.
- Waiver requirements are found in Chapter 4, page 34.

Home Health Agencies

Home Health Care Bill of Rights Requirement

Home Health Care providers are required to provide the Subscriber or the Subscriber's representative with written notice of the Home Care Bill of Rights prior to the date that services are first provided to that Subscriber.

The provider shall make all reasonable efforts to provide notice of the rights to the Subscriber or the Subscriber's representative in a language the Subscriber or Subscriber's representative can understand.

The Home Care Bill of Rights is available on the Minnesota Department of Health website (www.health.state.mn.us) under the Facility Certification, Regulation and Licensing section, and is available in several languages.

- Patient, Resident and Home Care Bill of Rights - MN Dept. of Health (state.mn.us)

In addition, DHS recommends that Home Care providers provide the Home Care Bill of Rights to Subscribers at least 30 days before terminating a Subscriber's services.

Electronic Visit Verification (EVV)

Providers must enroll in an EVV system to document that members are receiving services that are billed to Blue Plus. Providers can use either the Blue Plus selected system HHAeXchange for EVV or an EVV system of their choice, that is compatible with HHAeXchange.

HHAeXchange: [Minnesota Provider Information Center | HHAeXchange](#)

The EVV System will verify:

- Type of service performed
- Who received the service
- Date of service
- Location of service delivery
- Who provided the service
- When the service begins and ends